Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:40 PM BEVERLY D. MUSCHLITZ 07 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel <u> Annapolis</u> If Under 1 (State or Foreign 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 ☐ M 2 🖫 F Months Days Min APR 28, **73** 577-52-6622 1936 Wisconsin Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Director Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5156 Sands Road 20711 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Private University Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any finity or other traumatic event any Buy. Be Albert E. Decker Ruth Ε. Kreb 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eric A. Muschlitz, son 5156 Sands Road Lothian, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 **X**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 07/24/09 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb | 22. Name and Address of Facility Cremation Society of MD, 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 1 DAY **Physician** SEPTIC SHOCK /Medical Due to (or as a consequence of) Examiner 2 DAYS ASPIRATION PNEUMONIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dove to for an electroscopiones off Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> icate has been siç ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1∐Yes 2XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 ☐ Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled n by 4 Homicide Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis MD 21401 0 Parkway, 2001 Medical TIM 32 Régistrar's Signature Day, Year) 31. Date filed (Month. State 28 2009 Registrar

Ricky Dean Moody

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 09-05742

iony Boart moo		1- For State Certificate Of Registrar Certificate Of Registrar		Reg.	No. 201	9 2400
Physicia	in/	1. Decedent's Name (First, Middle,Last)		Date of Death Month Death	Day Year	3. Time of Death 1406 hrs
ledical Exami	ner	Ricky Dean Moody		July 22, 200	9 4c. County of Death	14001115
·)		Facility Name (if not institution, give street and number) Peninsula Regional Medical Center	4b. City, Town, or Location of Dea Salisbury	ith	Wicomico	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24		(MM/DD/YYYY) 9. Birth	nplace (State or
Director		220-70-2247 1X M 2 F 52 Yr		Nov 29	1956 Cou	Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
		Delaware Sussex Seafo	rd			1 Yes 2 X No
daryland 28a-f show 1 at once	먕	10e, Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
he Ma or 28)ire	6103 Delaware Line Reliance Road	19973	ŀ	USA	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers in the Maryland important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? (14. Race - Americ	can Indian, Black,
death or iten must_	nne	1 Yes 2 No	Yes, specify Cuban, Mexican, Pue	no Rican, etc.)		
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d with	Sor	17. Father's Name (First, Middle, Last)	18.Mother's Na	me (First, Middle, Ma	aiden Surname)	
ID 21215-0036: should be filed within 77 and Mental Hygiene. 77 is marked other than natic event, the Medical	Be (William Moody		Campbell		
21 lould d Mer is mar	70		ng Address (Street and Number of			
MD nd 2 sho alth and m 27 is			Stokesley Road osition (Name of cemetery,		Maryland 2 20c. Location - City or	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mould be filed within 72 inn: If item 27 is marked other than or other traumatic event, the Medical		1 Burial 2 V Cremation 3 Removal from State crematory or	other place)		ŕ	
Page ment tant:		4 Donation 5 Other Specify: Metro Cr	ematory Inc. 0			, Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Licenses Thomas Gregor 22	Name and Address of Facility remation Society 99 Frederick Ros	of Mary	land, Inc.	and 21228
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardia	c or respiratory arres	or heart	Approximate Interval
Medical	1 I	failure. List only one cause on each line.				Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
		Sequentially list conditions, b. Deep vein thrombosis of the right	leg			
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376 ificate ig phy	N/M	IF FEMALE: 23b. Was decedent pregnant in the page 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pre	gnancy	23d. Date of deliver Month	y Day Y ear
Box 687 e death certific the attending p	Physician/	past 12 months? 4 Pregnant at time of death 5	Other (Specify)			
Bo ne dear the a	hys	1 Yes 2 No 9 Unknown 9 Unknown	dadidas asuas chien in Dert I	23e Did tob	pacco use contribute to	the cause of death?
s, P.O. Box 687 irres that the death certifi signed by the attending 1 be detached for use as t	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part i.		2 No 3 Pro	
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tal Reco cian: The law certificate has	Con		00 DI	1 Yes 2	No 1 ✓ Y	es 2 No
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Division of Vital Records, tal or Attending Physician: The law requir as taler dealh. In Director: After this certificate has been seled in by the funeral director, page 2 should t	.T	1 Ves 2 No 28a. Date of Injury 28b. Time of			ow injury occurred	
on c ending ath. or: Af	tion	1 V Natural 5 Pending (Month, Day,Year)	1 Yes 2 No			
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DIVI spital or cours afte neral Dir	Certification:	4 Homicide determined (Specify)		or rown, st		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death oc	curred at the time, date and place,	and due to the cause	e(s) and manner as sta	ted.
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner: On the basis of examination and/or investi		es at the time, date a	29d. Date signed (Mo	
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	OCME	July 23, 2009	mui, Day, rearj
		Thurlow MI, King TRym.	U.U.IVI.E.			
_ \	8 8	Name and address of person who completed duse of dath (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltin	nore, MD 21201		
	tate					
Regis		JUL 28 2009 Deneur B. A.	arkel			

State Registrar 31. Date filed (Month, Day,

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South 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 07 2009 11:30 A M 26 Martin Mary Jo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel 1603 Bedford Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/28/1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Days Hours Months 1 □ M 2 🔀 F 80 MD Director 220-24-9942 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Glen Burnie **Funeral Director** Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Even net rust be no once. 21061 U.S.A. Bedford Road 1603 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: ð If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) State of Maryland Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor King Joseph Killikin ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen Burnie, MD 21061 1603 Bedford Road, Mr. Jack Martin / husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07/30/09 Crownsville, MD Maryland Vets. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, Singleton Funeral & Cremation Services, P.A. MO135 1 Approximate Interval Between Onset and Dear 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events that in the cause of th Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as attending p IF FEMALE: f yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 2 1 □Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Aft
bletely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one and manner stated.

within 2

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certified

28 2009

30 Name and add

(Item 23e) 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 Day 200 g ar JMTy **Physician** 2:45 A. M Amanda Moody /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie 43 Glendale Avenue Anne Arundel 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 M 2 TF 94 212-26-0924 Director May 18, 1915 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21061 United States Of America 43 Glendale Avenue 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🙀 No Specify: White Specify: 2 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Ida Mae Baker Clemeth Cage 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s
Department of Health as
Important: If item 27 Is
any Injury or other trav 43 Glendale Avenue, Glen Burnie, Maryland 21061 Mrs. Janis Rains (Daughter) 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of 1\(\frac{\text{\text{M}}}{2}\) Burial 2 \(\subseteq\) Cremation 3 \(\subseteq\) Removal from Side adowridge Memorial Pk 07/29/09 Elkridge, MD. 21075 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Gary L. Kaufman Funeral Home @ 21. Signatural of Funeral Service Licensee MMP, Inc, 7250 Washington Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) **Physician** 11-egr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-transit Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 2 0 No □Yes Ó 9 ☐ Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ The law requires 1 Yes 2 No 3 Probably 4 Unknown as been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 21 NO Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 ☐ Boaldence 6 ☐ Other (Specify) 1 Yes 2 ₩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manne Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, 29c. License number 29b. Signature and title of certified

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State Registrar 31. Date filed (Month, Day, Year) - 32 Spistrar's Signature

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32 Asistrar's/Signature

of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #2 Per Phy 6894 8/04/09 III State of Maryland Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July ^{Day} 2009 **Physician** ÎÓ, 2:20 PM M Evelyn B. Moore /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Brighton Gardens of Columbia Columbia Birthplace (State or Foreign Country) If Under 1 Year | II Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Dec 22, 19 **Funeral** Months Days Hours 1 □ M 2 🛱 F Yrs. 231-16-7530 89 1919 Virginia Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or Iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21042 USA 7110 Minstral Way #260 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. tiled within 72 hours after 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ρ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) 12 sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be til ment of Health and Mental H tant: If Item 27 is marked ott jury or other traumatic even James Henry Brown Berta Lee Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6289 Setting Star Columbia, MD 21043 Sandra Wolter/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation __3 ☐ Removal from State permit. Page Department o Important: If eny injury or once. 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee RONALD S W 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 3a. Part | Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence ol) Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Johknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificete hes t lirector, page 2 s autopsy performed 1 ☐ Yes 2 No nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) / L f Hospital: 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and titte of of death (Item 23a) (Type, Print) Linthicum, MI ia 3. Registrar's Signature 31. Date filed (Month, Day Year)
JUL 28 2009 State Backs Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	waryian			e of Dea	th and M ath		g. No.2	09	24007	-
			1. Decedent's Name (First, Middle, I	Last)						2. Date of Death Month	Day	Year	3. Time of Death	
	Physici: /Medic		Betty Irene Maje	wski					}	July	6	2009	11:40 A M	
The same	Examin		4a. Facility Name (If not institution, g		nber)		4b. City,	Town, or Loca	tion of Death			nty of Death		
-			Heritage Harbor	Heath &	Rehab		Annaj	•				Arund		
	Funeral		Social Security Number 6	. Sex 1 □ M 2 🖾 F	7. Age (In yrs.		If Under Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Nov 11,	Year)	9. Birth	place (State or Foreign	ŀ
	Director		218-58-7381	ILIM ZELF	7	6 Yrs.				Nov 11,	1932	Penr	sýlvania	_
1	Dui A		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	, Town or Lo	cation					1	0d. Inside City Limits	
Ì	laryle sho	ō	MD Anne Ar	unda1		napoli							1∐Yes 2⊠No	
2	28a-1	Director	10e. Street and Number	under	1111	парота	10f. Zip	Code		10	a. Citizen o	of What Cou	ntry?	_
	Mith Ba or	Ö	2700 South Hav	an Road				401			USA			
4	ns 23	era	11. Marital Status		dent Ever in U.	S. 13. 1			ic Origin? (Sp	ecify Yes or No-		Race - Ameri	can Indian,	_
(0	riter d	Funeral	1 ★ Never Married 2 Married	Armed For	rces? 2 🔀 No		If Yes, spe	cify Cuban, Me	exican, Puerto	Rican, etc.)	1	llack, White,		
036	urs a al", o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	re ates:		1 □ Yes	2KINo Sp	ecify:		Spe	_{cify:} whi		
21215-0036	2 ho	Completed	15. Decedent's (Specify only highest)	Education		16a. Dece	dent's Usua	al Occupation rk done during	most of work	na 1	6b. Kind of	Business/Ir	dustry	
21	thin te.	nple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	se retired)	Theor of their	9		0		
21	illed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Madical Examinan Liust by notified a	Co	9	- 0	<u>.</u>	als	able			Communication and	non			
pu	be filed within 72 hours after death with the Marylan Hylgiene. Hylgiene, Hylgiene, do ther than "natural", or items 23a or 28a-f show event, the Maclical Examilment with the notified at	Be	17. Father's Name (First, Middle, La	st)						(First, Middle, M	aiden Surn	ame)		
<u>Ş</u>	2 should be filled within and Mental Hygiene. is marked other than aumatic event, the Mark	은	John Majewski							eValley	0'4 T	04-4- 7:	- 0-4-1	_
Maryland	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship				-			al Route Number,			FL 32162	
oî :	1 and 2 Health a tem 27 is		Margie Thalber 20a. Method of Disposition	t/Sister	20b. F							n - City or T		_
JO.	ages int of t: If it		1 ☐ Burial 2 ☐ Cremation 3		State	lace of Dispo emetery, crei	matory`or o	other place)						
Baltimore,	artme vrtan injury		4 Donation 5 Other (Spe			22	2. Name ar	nd Address of	Facility					_
Ва	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lice Ronald 5	Wade, Di	tector			-		655 W.	Balti	more S	Street	
			23a. Part 1. Enter the disease, or co	emplications that c	aused the deat	n. Do not en	ter the mod	o re, Ma de of dying, su	iry Land ch as cardiac	or respiratory arre	st,		Approximate Interval Between	
	hysician		shock, or heart failure. List or Immediate Cause (Final	nly one cause on e	6	P	14.6.						Onset and Death	
	/Medical		disease or condition resulting in death)	a. Luy Due to	or as a conseq		MCY	cus						
E C	Examiner			b										
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		or as a conseq	uence of):								
3	nd nd transi	Examiner	Cause (Disease or injury that initiated events	с										_
00	oe exe sian a urial-	Ě	resulting in death) Last	Due to	or as a conseq	uence of):								
8760,	care be executed physician and the burial-transit	dical		d										
		Me	IF FEMALE:	23c If yes out	come of pregna	ncv					004	Data of dali		
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live I	oirth 2☐ Feta nant at time of c	Ideath 3[☐ Ectopic p☐ Other (se				230.	Date of delivery	Day Year	
o }	that the de ned by the detached	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9 Unkn		leatii 5	_ Other (s)	Decity)						
a .	that t		Part II. Other significant condition	s contributing to de	eath but not res	ulting in the u	nderlying o	ause given in	Part I.	23e. Did tob	acco use o	ontribute to	the cause of death?	
sp.	uires n sign Id be	d by	Corebral 1/4	44.1	Yreat	he ros	du	10		1 □ Ye	s 2 N	o 3 Pro	bably 4 🗌 Unknown	1
0	w requir s been s should	ete			//			./		24a. Was ar	24	b. Were aut	opsy findings available	9
0	\$ 10 07	_	l .	,									ompletion of cause of	
Rec	nelaw ehas ige 2 s	dmc			•					autops: perform	red?	death?		
tal Records,	an: The law tificate has or, page 2 s	e Completed	25. Was case referred to medical	,				26	Place of Deal	autopsy perform 1 🗆 Yes 2	ned? No		2 (X No	
Vital Rec	ysician: The law is certificate has director, page 2 s	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 □ D	Othor		autops perform 1 □ Yes 2 h (Check only one	No No	death? 1 ☐ Yes	2 (20) No	
of Vital Rec	Pnysician: The later this certificate has rail director, page 2	Be	examiner? 1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time o		OA Other: 4		autopsy perform 1 🗆 Yes 2	ned? No nce 6 🗆	death? 1 Yes Other (Spec	2 (20) No	
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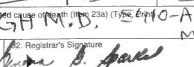
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24008 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Ruth F. Metallo 1 1 1 1 1:35 P July 21 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel County Marley Neck Health and Rehab. Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 ☐ XF Director 215-09-5552 90 Oct. 9, 1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or dical Examiner must be Funeral U.S.A. 8403 Echo Drive 21122 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1∐Yes 2∐WNo Specify: <u>}</u> Specify: 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) lith and Mental Hygiene. 27 is marked other than " r traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) 12 Credit Card Processor Equitable Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Michael Lockner Maude Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any Injury or other tr once. 8403 Echo Drive Pasadena, Maryland 21122 Patrick Metallo (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/22/09 Glen Haven Mem. Pk. Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 23a. Part1, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIOVASCULAR Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Certification: To 1 🗌 Yes 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 👺 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

27 2009



29c, License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician lonth Day Year 700 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Milford Mill Road Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours 213.22.226 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show injury or other traumatic event, it's Medical Exacting the political at MD Baltimore Baltimore 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Mill Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify à Specify: 3 ack 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Anne Avundel Co. estodian Leth arade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tican lettie aut's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milford Mill Mayo Road Battinione NO 21246 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) Rest Cemetery 30 07 Han Wer, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greenefunerafsus Vaushn Idalistrum MD 2113 23a. Part 1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or hear vailure. List only one cause or each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or de a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be execu the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Medical Certification: To Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes s after death 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my option, death occurred. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

To the within Z on the complex Complex Registrar

tate 31. Date filed (Month, Day, Year) trar

30. Name and address of person

308 M D 25 22. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

. square

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician EUGENE 200 uch /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BAL HOSPITAL CENTER DALIS WWW union cothenes If Under 1 Year | If Under 9. Birthplace Country) 5. Social Security Number Sex. 1 M 2 □ F 7. Age (In yrs. last birthday) (State or Foreign **Funeral** 220.22.53 Min. Months Hours Davs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, it a Modical Examiner must be notified at MD Yes 2 ☐ No **Funeral Director** Baltimore Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 30CK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Bathmore Painter 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Price -111100 ဂ္ 19a. Informan's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Marie Price/wife of Health a . Rogers Avenue Baltimore MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If It any Injury or on once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 07/30/09 OWIND MILL, MD Garrison . Greate Funeral SVO 21. Signature of Funeral Service License 22. Name and Address of Facility Vaughor C. Koad Randulstown MD 2133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi attencing physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 ACUTE RESPIRATIONLY THIGHT Abut RENAL FALL WARE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t Completed STAGES 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ Ho 24a. Was an RICHT HEP -STAPHylocother Aunter 1 per · METAICILLE RESISTANT To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director; After this certificate completely filled in by the funeral director, page 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No Hospita 2 3 10 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 1 □ Uppatient 2 □ ER/Outpatient 3 □ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural la le of lijury - At home, farm, street, factory, office building, etc. (Speafy) 1 □Yes 2 XNo 2 Accident 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number City or Town, State) 91094 benty 30 Randa (Katoun, MDZ1133 4 Homicide Homo NWSING How Rendelletoun MD2[133]

1 * Certifying Physician: To the best of my kn w dge, death occurred at the time, date and place, and due to the cause(s) and wanner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar on Lando

31. Date filed (Month, Day, Year)

28 2009

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONTANTA MO

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician 27 Day 2009 11:55p ^M Sybille Page /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Annapolis

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, FEB 26, Heritage Harbour Health and Rehab Center Anne Arundel lace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F Yugoslavia 212-38-8219 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experies. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2X No Director Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12547 Windover Turn 20715 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Henerari Agatha Kirschner ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12547 Windover Turn Thomas A. Page husband Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 07/28/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 687605 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an 2 🔲 (No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

10

State

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year,

Baltimore, Maryland 21215-0036

	/W
1	Exa
Division of Vital Records, P.O. Box 68760,	o the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
Division of Vita	o the Hospital or Attending Physician: vithin 24 hours after death.

		For State Registrar	ease i			and / De		nt of ⊢	Ensure A lealth and N Death	Mental Hyg	_	noie.	21.012	j.
Physici /Medio		1. Decedent's Name (First, M Shirley Hsiac								2. Date of Dear Month July 25	Day	Year	3. Time of Death 11:45 I	
Examin		4a. Facility Name (If not instit	ution, give		mber)		4b. Cit		Location of Death			ty of Death	County	
Funeral Director		5. Social Security Number 040–86–0039	6. Sex	(]м 2 ≱ F	7. Age (In y 42	rs. last birth	Months	er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March (9. Birthr	place (State or Foreign ntry) PCI, Talwan	
aryland show	٥٢	Usual Residence of Decedent 10a. State 10b. Con	unty			City, Town o						1	0d. Inside City Limits 1	
with the M 3a or 28a-f	Funeral Director	Maryland 10e. Street and Number 501 St. Paul	N/A		.814	altimo		ip Code	21202	1	0g. Citizen of	f What Cour Canad	ntry?	
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examinet must be notified at	by	11. Marital Status 1 ☑ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo	Married	12. Was Dece Armed Fo 1 ∐Yes If Yes, Gi Year or D	edent Ever in prces? 2 12 No ve	u.S.	13. Was Dec If Yes, sp 1 □ Yes	edent of H ecify Cuba	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	Bla	ace - Americ ack, White,	can Indian,	
hin 72 hou e. an "natura Medical I	Completed	15. Dece (Specify only his Elementary/Secondary (0-		cation e co <i>mpleted)</i> College (1	I-4or 5+)	16a. D	Decedent's Us Give kind of и ife. DO NOT	uat Occup ork done o use retired	ation during most of work f)	king	16b. Kind of I	Business/In	dustry	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exa	To Be Con	12 17. Father's Name (First, Michael Pan	dle, Last)	5+	•		Mu	sicia	an 18. Mother's Nam Wee Kiar			Pianis ame)	t	
and 2 shou lealth and M m 27 is mar her traumat			ionship <i>(Ty</i> S i ste:			29	Coving	yton		Ottawa, O		K2G(6B4	
nit. Pages 1 artment of H ortant: If ite Injury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe 21. Signature of Fugeral Ser	er (Specify)	<i>a</i>	State	vans I	oisposition (No crematory or Unera.	l Cha	pel 20	Date 7 27, 009	Fore	st Hi	ll,Maryland	
permi Depa Impor any Ir		1 Who	7	. 10	w,/		Peace: 2325	ful A York	Iternativ Road !	ves Fune: Finonium or respiratory ar	ral&Cre Mary.	ematio land	21093 P.7 Approximate Interval Between	7 0
Physician /Medical Examiner		23a. Party Enter the disease shoot, or healt fellere. Immediate Cause (Final disease or condition resulting in death)	List only or	a/	each line. Bre (or as a cons	r > 1	(111	1001	R				Interval Between Onset and Death	
ate be executed only sician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1		(or as a cons									
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2		birth 2 ☐ F nant at time	etal death	3 ☐ Ectopid 5 ☐ Other (у			Date of deliv	rery Day Year	
quires that en signed t uld be deta	by	Part II. Other significant cor	ditions cor	ntributing to d	eath but not	resulting in t	he underlying	cause giv	en in Part I.		bacco use co es 2 ☑ No		the cause of death? bably 4 ☐ Unknown	1
: The law re cate has be page 2 sho	Completed									24a. Was a autop: perfor 1 □ Yes	SV	prior to co death?	opsy findings available ompletion of cause of 2 No)
Physicians er this certific eral director,	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death	-	28a. Date	of Injury	28b. Tir		28c. Injui	er: 4 □ Nursing H	th (Check only or ome 5 ☐ Resid 28d. Describe h	ence 6 🗗		intospace	ê.
or Attending fter death. birector: Afte in by the fund	Certification:	3 ☐ Suicide 6 ☐ Co	nding restigation ould not be termined	28e. Place	of Injury - A	it home, farn	M n, street, facto		k? Yes 2 □ No	28f. Location (S City or Tow	treet and Nur n, State)	mber or Rur	al Route Number,	
Hospital of 24 hours a Funeral Detely filled i	Medical Ce			ner: On the b					me, date and place					
To the within To the comple	Med	29b. Signature and title of ce	rtifier	A		un		9c. Licens			29d. Date sign			
3 V		M And 30. Name and address of pe W. A. R. L.	rson who co	empleted caus	se of death (Item 23a) (T	ype, Print)	har	les St.	Balto	mo	21	20%	
Sta Registr		31. Date filed (Month Day,)	2009	Lever 32. F	Registrar's Si	gnature	N.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July **Physician** 2009 26 9:20 A Rikiko Poole /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll 144 Sullivan Rd. Westminster 8. Date of Birth (Month, Pay Year) 1 9. Birthplace (St. Country)
April 10,1931 Tokyo If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2 F Hours Min 78 218-42-5148 Yrs. **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examination is notified at MD Westminster Carroll 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 144 Sullivan Rd. 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 → Married Specify: Japanese Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene. College (1-4or 5+) Service Elementary/Secondary (0-12) Blind Commision 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk pe Kuni Tanaka ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clarence S. Poole-husband 144 Sullivan Rd., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State South Carroll Crem. 7-28-09 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home, P.A. 21. Signature of Funeral Service Licensee homas 6 254 E. Main St. Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final days **Physician** Pneumonia resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and -trar Due to (or as a consequence of): burialphysician at the burial O. Box 68760 Physician/Medical the attending posterior that the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for Yes 2 No 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 € No 3 ☐ Probably 4 ☐ Unknown Diabetes Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No 1 ☐ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 2 completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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State

31. Date filed (Month, Day, Year) 28

29b. Signature and title of certifier

Ellen Reilly Farrell CRNP 3250 Starting Gate Ct.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Woodbine

21797

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2009 6 onald /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Bayvieur Medical Center Battimore

7 Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 | 1900 Examiner Johns Hopkins Birthplace (State or Foreign Country) **Funeral ™**M 2□ F 217-12-7353 84 AUG.11,1924 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show any Injury or other traumatic event, if a Medical Evaning must be notified at once. 1 X Yes 2 No Directo Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 U.S.A. 624 S. Lehigh St. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White WWII \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Yrs. General Electric Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cora Mae Goodrich Walter Pitt Pentz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 383 Jaybea Ct. Glen Burnie,MD 21061 Mrs. Dawn P. Ward / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/2009 Atlantic Crematory Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 MONZI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Houte Physician Myocardial resulting in death) /Medical Due to (or as a consequence of) Examiner eranary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). O. Box 68760. Physician/Medical cate has been signed by the attending I page 2 should be detached for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. 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1 ☐ Yes 2 ☐ No fibrillator Implanted Recentl 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No ≥ ER/Outpatient 3 □ DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury Natural Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

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31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and

4940 mo 2. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

m

mD 21224 BALTIMARE AVENVE

29d. Date signed (Month, Day, Year)

State Registrar

MSTERN

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 19, 2009

State

Registrar

me and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

ature and title of certifie

8

Laron Locke MD.

Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23 2009 **Physician** Danne /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 23, 1935 Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Days 74 1 M 2 X 185-28-9936 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Maryland Wicomico Salisbury 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 425 Forest Lane 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 P No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or ite 1 Yes 2 If Yes, Give Year or Dates: ¹XXNever Married 2 ☐ Married White 1 Yes XXNo Saltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Registered Nurse 12 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event. Be Margaret Ann Wright Sullivan Paul Thomas Marion Parrish ည traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 807 W. Padonia Road, Cockeysville, MD 21030 Department of Health a Important: If item 27 is any injury or other traionce. Brother A. Scott Parrish 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State Atlantic Crematory 7/26/2009 Glen Burnie, Maryland 5 Other (Specify) 4 Donation 21. Signature uneral Service License 82. Name and Address of Facility. Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enjoy the disease, or complications that caused the shock, or fleart failure. List only one cause on each line. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ruptured Immediate Cause (Final thoracoab dominal **Physician** disease or condition resulting in death) Du to (or as a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Dise to for as a consectionou off The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 s has 2 X No 1 Yes 2X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death, 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide

Hospital or Attending Physician: Director: /

within 24 hours aft

To the Funeral Dir

completely filled in within 2 To the F

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Medical

29a. Certifier

(check only

29b. Signature and title of certifier

[MOD 31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/200

t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RFS-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 20 2009 Т. 3:10P Joanne Pavne 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Linthicum Anne Arundel County Tate Hospice House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Days 1 □ M 2 🗓 F 63 26, 1945 Maryland Dec. 557-60-8958 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2 X No Maryland Anne Arundel Davidsonville 10g. Citizen of What Country? 10e. Street and Number 21035 U.S.A. 3750 Valhalla Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2X No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Sales Associate Montgomery Wards 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jack Stowe Mary Luckus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey L. Payne (Husband) 3750 Valhalla Court Davidsonville, Maryland 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/24/09 Bayview Cremtory Baltimore, Maryland 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home.P.A 3204 Mountain Road Pasadena, Mary Maryland 21122 Collins 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition disease or condition Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's consequence of Due to (or as a consequence of): yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Completed

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ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, Inc. Natical Exeminar must be notified at

within 72 hours after

2 should be finance and Mental I

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev

Baltimore, Maryland 21215-0036

sician and burial-trans attending physician for use as the buria the signed by After this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

the death certificate be executed

Box 68760.

P.O. |

Division of Vital Records,

Hospital or Attending Physician:

the

Examiner Physician/Medical 2 Completed Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □Yes 2 No 9 Unknown

25. Was case referred to medical examiner?

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

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performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

2 X No Olbica

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

1 Natural 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated

29c. License number 29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

31. Date filed (Month, Day, Year)

State Registrar

Medical

JUL 27 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July **Physician** 2009 8:00 A M Eunice Irene Roe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 11,1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 86 Yrs 295-12-2788 Michigan Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County TIS 23a or 28a-f show 1 ☐ Yes 2 No Director Maryland Baltimore Perry Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9124 Snyder Lane 21128 **USA** Funeral permit, Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Modical Example mental once. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Devereux Foundation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Dana Chase Elsie Mary Brown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen D. Roe, Daughter 122 Maple Avenue Troy, New York 12180 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 107/24/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor জিলান্ত্রীভিচিষ্টি Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas S 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of burial-tran Due to (or as a consequence of): Zuhia. Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 □No Division of Vital Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WS DU 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe

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State Registrar 31. Date filed (Month, Day, Year)

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28 2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24, **Physician** 2009 Doris M. Ringrose July 4:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cranberry Cottage Assisted Living Glen Burnie Anne Arundel . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 □ M 2 XF 215-05-3797 Maryland 90 APR 26, Director 1919 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Inten 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 101 McGuirk Drive 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Completed by Specify: 3 ☐ Widowed 4 🙀 Divorced White Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ship Building Switchboard Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blades Mae item 27 is marke other traumatic Alfred Evans ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Judith M. Zanti, daughter 101 McGuirk Drive Glen Burnie, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 07/24/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, 21. Signature of Funeral Service Licensee George MacNabb Inc. 2 Ma 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Ofiset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** wint 44461 resulting in death) /Medical Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as e consequence of): by Physician/Medical Examine Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and P.O. Box 68760d Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and marmer stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 1411 Madison Park Dr., Suite 2-B

30. Name and address of person who completed cause of death (Item-23a) (Type, Print)

32. Registrar's Signature

Elliott Gorbaty, M.D.

D0020904

July 24, 2009

Glen Burnie, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 11 9

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1 - For State Registrar	
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			1 - For State Registrar	Cer	tificate of Death	Reg.		L 40 L 0
			1. Decedent's Name (First, Middle, Las	1)		2. Date of Death Month	Day Year	3. Time of Death
Į	Physici /Medi		Mary H. Rowbott	om		July 19,	2009 Year	1:15 AM M
>	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			1916 N. Forest	Park Avenue	Baltimore			
	Funeral Director		203-10-0731	7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Mar 26,	9. Birth 1917 Oh	place (State or Foreign Intry) LO
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	f ehc	5	MD	Baltimor	е			1X Yes 2 □ No
	3a or 28a-	i Director	10e. Street and Number 1916 N. Forest P		10f. Zip Code 21207	10g.	Citizen of What Cou	intry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 ie marked other then "natural", or iteme 23a or 28a-f ehow any njury or other traumatic event, the Medical Examinat remail be motified at anote.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2X No	Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto ☐ Yes 2X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:whi	, etc.
21215-0036	vithin 72 h ne. hen "natu e Medical	mpletec	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) (Give life. L	ent's Usuat Occupation kind of work done during most of work DO NOT use retired)	ang 16b	o. Kind of Business/I	ndustry unk
	lied v lygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)	0 typ	esetter	e (First, Middle, Mai	idan Sumama)	
anc	ntal h	Be	Anthony Joseph	Crookston		ene Helmai		
2	d Me d Me mark matic	2	19a. Informant's Name/Relationship (7		g Address (Street and Number or Rur			in Code)
Maryland	d 2 s th an trau		Carol Jean Keati		N. Forest Park A			
Baltimore,	Pages 1 arent of Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Hemoval from State	sition (Name of latory or other place)	Date 20d	c. Location - City or	Town, State
Balti	pemit. P Departm Importer any njur		21. Signature of Funeral Service Licens	Wade Streetor St	Name and Address of Facility ate Anatomy Board 1timore, MD 2120		altimore :	Street
1	Physician /Medical Examiner	ər	Immediate Cause (Rinal disease or condition resulting in death)	lications that caused the death. Do not entended the cause on each line.	or the mode of dying, such as cardiac	or respiratory arrest,		Approximate Intervat Between Onset and Death
68760,	death certificate be executed e attending physicien and id for use as the burial-transit	Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				
P.O. Box (death cer e attendir ed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliment	very Day Year
	9 <u>5</u> 6	by	Part II. Other significant conditions co	entributing to death but not resulting in the un	iderlying cause given in Part I.		co use contribute to	Committee of the commit
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Vital	ysicien: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?	Hamital:		h (Check only one)		
of	w 5	. To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of			e 6 Other (Special	nfy)
Division	ding h. After tune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how		48
Div	- 9		4 Homicide determined	building, etc. (Specify)		City or Town, S		
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	one) 2 Medical Exam	vsicien: To the best of my knowledge, death iner: On the basis of examination and/or inv and manner stated.	estigation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
	To To	2	29b. Signature and title of certifier William . Flor		29c. License number	2^	Date signed (Month	LOO9
				ompleted cause of death (Item 23a) (Type,	S L. Ho Paterx	eint Ca	6-5	درم

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year GAIL L. ROLF 6108 Am 2009 26 JUly 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne 6len Burne Hrunde Baltimore Washington Medial Center Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 □ M 2 🗓 F 214-62-1559 Jan 3, Maryland 1953 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 1 ☐ Yes 2 No Glen Burnie Maryland 1 4 1 Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21060 141 William Chambers Jr. Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 Tyes 2X No Specify Specify. White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mother Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Barowski Thomas Schneider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 141 William Chambers Jr. Drive, Glen Burnie, Maryland Joseph T. Rolf, Jr. (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 7/28/09 Bayview Crematory, Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Signature of Fungral Service Licensee Kevin E Ecker 3204 Mountain Rd., Pasadena, Md. 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, a consequence of): if any leading to it. neare cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 XNo 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide

Physician /Medical Examiner Examiner law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla attrement of Health and Mental Hygiens of a cortant; I flem 27 is marked other than "natural" or items 23a or 28a-f show injury. I flem 27 is marked other than "natural" or items 23a or 28a-f show injury or other traumatic event, the "nacical Examinar must be rectified at

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau

Baltimore, Maryland 21215-0036

burial-trar attending physician for use as the buria signed by t d be detach peen has

Physician/Medical

2

Completed

Be

Certification: To

29a. Certifier (Check only

29b. Signature and title of certifie

certificate funeral director, this

Division of Vital Records, P.O. Box 68760, or Attending Physician: The within 24 hours after death

To the Funeral Director:
completely filled in by the t Hospital

> State Registrar

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Drive Glen Burnie MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Jul 3:18PM la 24 han 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Center Medica 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🕶 F Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 □ No Funeral Director timore 10f. Zip Code 10g. Citizen of What Country? Street and Number 2120 items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0, Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ģ 3 XWidowed 4 ☐ Divorced "naturai" Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. other than "I Cellege (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 Is marked other th: any injury or other traumatic event, Italiance. imore 18. Motheris Name Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip ode) Balto. 2600 Method of Disposition 20b. Place of Disposition cemetery, crematory Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Nat'I Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Abdomina **Physician** Autic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) been signed by the s should be detached t ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy Yes 2 ☐ No 1 🗆 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 15686979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL PL- BALTIMORE, MO ABIMBORA UBAFEMI 301 ST.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

28

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 27 2009 July 11:02 a.m. Stipa /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9118 Summer Park Drive Parkville Baltimore If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country)
 Virginia If Under 1 Year 8. Date of Birth (Month, Day, Year) Oct. 3, 1927 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1□ M 21√F Yrs. 81 Director 226-30-3602 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at once. 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 United States 9118 Summer Park Drive Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2√∑ No Specify: \$ 3 StWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Burley Isdell Annie Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita J. Sorrentino/ Daughter 9118 Summer Park Drive, Parkville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 28. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2009 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner pertension physician and is the burial-transit Tha law requires that the death cartificate be executed Division of Vital Records, P.O. Box 68760, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) Se attanding p signed by the a d be datachad for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown Chronic \$ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? paga 2 should After this certificata has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 hesidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28d. Describe how injury occurred Injury at Work? I or Attending Fafter death. 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of-certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chen

32. Registrer's Signature

State Registrar

3

Alexander

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17&18 Per FH G893 7/29/09 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** July 2009 26 2:00 A Nancy Jane Shultz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Eltern Haus</u> Dayton Howard Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Davs 1 □ M 2 🙀 F Months Director 04/24/1923 195-16-2901 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Experience must be notified at 1 ¥Yes 2 No Director MD Howard Dayton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 21036 U.S.A. 4201 Linthicum Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Healthcare 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental unk John Warner unk Martha Arndt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Coffman/Son 7812 Metacomet Road, Hanover, MD 21076 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State Ardent Cremation Services 107/28/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services
7522 Connelley Drive, Ste. N Hanover, MD 21076 21. Signature of Funeral Service Licensee Laura C. Hardesty M01197 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical CRAL DECURITUS Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 2 Q No 9 Unknown 9 Unknow signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 3 Probably 4 ☐ Unknown 1 🗆 Yes completely filled in by the funeral director, page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ Ho 24a, Was an autopsy performed? Yes 2 certificate 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Watural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No death 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the the 29c. License number 29b. Signature and title of certifier Name and address of person who comp of death (Item 23a) (Type, Print) eted cause (GITAL DR. LINTHICUM 5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 28

DHMH 17 Rev 1/2001

3. Time of Death

3:100

9. Birthplace (State or Foreign

Baltimore, MD.

State of Maryland / Department of Health and Mental Hygiene-

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24

Physician
/Medical
Examiner

Pages 1 and 2 should be filed within 72 hours after death

permit.

and Mental Hygiene. is marked other than

of Health a

other traumatic

Department of Important: If it any injury or conce.

Physician

Examiner

/Medical

physician and the burial-trans

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signed by the a

cate has I page 2 s

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

pe

P.O. Box 68760,

of Vital Records,

Division

Baltimore, Maryland 21215-0036

by Funeral

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Examine

Physician/Medical

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Completed

Be

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Certification:

Medical

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Fred Lester Simon, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept.19,1917 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 ☑ M 2 □ F 213-10-1295 Director 91 Usual Residence of Decedent 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f sho Director Maryland Baltimore County Towson with the 10g. Citizen of What Country? 10f. Zip Code

10d. Inside City Limits 1 □Yes 2 No

10e. Street and Number 806 E. Seminary Ave. 11. Marital Status 1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

21286 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) W.W.II 1 ☐ Yes 2 No Specify.

14. Race - American Indian, Black, White, etc. Specify: White

United States

16b. Kind of Business/Industry

2009

Baltimore

4c. County of Death

15. Decedent's Education (Specify only highest grade completed)

1XYes 2 □ No If Yes, Give Year or Dates:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Vice President

Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Surname)

P.H.H. Corporation

F. Lester Simon

Vera D. Heckman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, Maryland 21286

19a. Informant's Name/Relationship (Type. Print) (Wife) Mary Elizabeth (nee Eatmon) Simon 20a. Method of Disposition

806 E. Seminary Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Evans Funeral Chapel

July 26, 20c. Location - City or Town, State 2009 Forest Hill, Maryland

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) ineral Service Licer

Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093

23a. Parf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart tellure. List only one cause on each line. Immediate Cause (Final

CLOSTRIDIUM DIFFICILE Due to (or as a consequence of):

Approximate Interval Between Onset and Death DAYS

resulting in death) Sequentially list conditions

COLITIS Due to (or as a consequence of)

PNEUMONIA

College (1-4or 5+)

DAYS

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

Due to (or as a consequence of):

23d. Date of delivery

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death
4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy

2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

Year

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 2 Accident 3 Suicide

4 🗌 Homicide

5 Pending investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 ☐ Yes

29a. Certifier

t 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one)

29b. Signature and title of certifier ael

29c. License number D36663

29d. Date signed (Month, Day, Year) 415000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 1 D 7671 32. Registrar's Signature 051 DRIVE TOWSON, MARYLAND 21204

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#9perFH, G893, 7/28/09, WS
State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Paul Gerald Smith 2. Date of Death 3. Time of Death $200 \tilde{9}^{\text{ear}}$ July 22 Day Physician 3:17 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford County Upper Chesapeake Bel Air 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 1939 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** year 1939 Couintry) Banner Elk, NC Days Hours Months 216-36-8057 69 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at Maryland Harford County Bel Air Director 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 610 Moores Mill Road Apt. C 21014 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)
Unk • Assistant Manager Department of Health and Mental Hygie Important: If Item 27 is marked other t any injury or other traumatic event, In once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Woodrow Smith Mabel Helen Hodges 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Moores Mill Road, Apt C., Bel Air, MD 21014 Mrs. Grace Smith (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Forest Hill, Maryland Evans Funeral Chapel 07/25/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - BelAir 3 Newport Drive, Forest Hill, Maryland 21050 tam 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acure **Physician** Coronari Syndrome un known disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Preumonia Unknown Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of). the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending pl for use as tl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be c Completed by renal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STRICK discuse 24b. Were autopsy findings available prior to completion of cause of death? cardiac arrest 24a. Was an autopsy performed page failune Respiratory 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attended within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065421 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Drive, Bel Arr, MD 21015

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-00

Records,

Vital

Division of

gar

Smith

Christa R. Fisher, MD 500 UPPER

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			Please Type or Print AMEND, ITE State of Mar	in Black	Indelible Ink	A. Ensure All	Copies Are	Legible.	
			For State Of Ivial State Of Registrar		Certificate of		Reg. N	/ 11111	24021
	Physici /Medio		Decedent's Name (First, Middle, Last) ELIZABETH AN	N SHIF			July 31	2009	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give street and number)	1 0.	, ,	or Location of Death	4	c. County of Deat	
1	Funeral		Baltimore Washington Med 5. Social Security Number 6. Sex 7. Age	d Gtr (In yrs. last birth	day) If Under 1 Year	en Burnie	3. Date of Birth		Arundel hplace (State or Foreign
	Funeral Director	-	5. Social Security Number 216 1 M 2 F 7. Age 1 M 2 F Usual Residence of Decedent	-	rs. Months Days	Hours Min.	3. Date of Birth (Month, Day, Yea)1/01/19	24 Ma	aryland
	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ent, the Medical Evertiner must be notified at	ō		10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	within 72 hours after death with the Marylan ene. than "natural", or items 23a or 28a-f show	Director	MD Anne Arundel		Balti 10f. Zip Code	lmore	10g. (Citizen of What Co	untry?
	h with	al D	112 Weldon Road		21	1226		U.S	.A.
	ems :	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent of I	Hispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give		1 □Yes 2 🗹 No			Specify:	
5-0036	hour	ed t	15. Decedent's Education	16a.	Decedent's Usual Occu	pation		Kind of Business/	hite Industry
215	hin 72 e. an "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		Give kind of work done life. DO NOT use retire	during most of working			
157	e filed wit al Hygien other th vent, inc	Con	12		Homema	T		Own H	ome
ر and	should be filed vind Mental Hygie marked other tumatic event, to	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (en Surname)	
₹	2 should I and Men Is marke aumatic	으	Joseph McGrain 19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stree	Loretta		or Town, State, 2	Zip Code)
ELI工人名モアル Jih altimore, Maryland 21	od 2 27 is r tra		Jan Sullivan/Daughter		57 Veneti				
ore,	es 1 ar of Hea fitem rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		Disposition (Name of crematory or other pla			Location - City or	
II.	Pages tment of tant: If It jury or o		4 ☐ Donation 5 ☐ Other (Specify)	Mt. Ca:	rmel Cemet	tery 07/25	5/09 F	asadena	a, MD
Bam	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licensee						Home, PA
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do n		era Drive ing, such as cardiac or		iena, Mi	21122 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	mic C	Endin	71			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a continuous)			0. /00			
	- Adminion	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a condition)	consequence o	yeny !	Offerix			
Alsi	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	rentro	" A	manit			
60,8	be executed ician and burial-transit		resulting in death) Last Due to (or as a	consequence of	r):	1	0.		
6876		dical	Cd. ifmy	obijn	while for	1 monom	dies	ie.	
Box 6	certifi nding use as	√/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	pregnancy				23d. Date of de	ivery
	The law requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the	Physician/Medic	in the past 12 months?		3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	cy		Month	Day Year
P.0	hat the ed by ti detach	Phy	9 Unknown Part II. Other significant conditions contributing to death but	not resulting in	the underlying cause gi	ven in Part i.	23e. Did tobacc	o use contribute to	the cause of death?
rds,	quires t n signe ald be	d by					1 □ Yes	20 No 3 □ P	robably 4 🗆 Unknown
ဝ	aw rec as bee 2 shou	Completed					24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
<u> </u>	The I	Com					performed	death?	2 No
Vita	Physiclan: r this certific ral director, I	Be	25. Was case referred to medical examiner?		Ot	26. Place of Death	, ,		
Ö	Phys r this rat dir	: To	1 Yes 2 No		patient 3 DOA	4 Li Nursing Hom	e 5 Residence		cify)
<u>o</u>	nding ith: :: Afte e fune	ation	1 Natural 5 Pending (Month, Day, 2 Daccident investigation	rear) In	jury Wo	rḱ?]Yes 2 □No			
Division of Vital Records,	or Atterder	Certification: To		y - At home, fari (Specify)	m, street, factory, office	28	3f. Location (Street City or Town, St	and Number or Rate)	ural Route Number,
Ω	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certiffer Certifying Physician: To the best of	my knowledge	death occurred at the	time, date and place, a	nd due to the cause	e(s) and manner a	s stated.
	the Ho in 24 h the Fur	Medical	(Check only one) 2 Medical Examiner: On the basis of each and manner state						
	To t	Σ	29b. Signature and title of certifier		29c. Licen	se number	29d. I	Date signed (Mont	h, Day, Year)
			30_Name and address of person who completed cause of dea	ath (Item 23a) /	Type, Print)	3911	177	m 21	2009.
	0		Chilky Seith 301 Hi	cital n	sive Clair	Brand. n	11A . 2 M	1.	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar	Synature	ales		1-11		
	Registr	ar	JUL 28 2009 Sener	1. 19 m					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#2perPHYS G893 7/28/09 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Montbuly 22ay 2009 Year **Physician** Driggs 26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BAltimolf 5 Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours Min. 1□ M 2**X**F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County "natural", or items 23a or 28a-f shovidical Examiner must be notified at RaHimore 1 Yes 2 No by Funeral Director 10f. Zip Code 2/22 10g. Citizen of What Country? 10e. Street and Number uzerne Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten important: If Item 27 Is marked other than "hatural", or iten any injury or other traumatic event, the Medical Examiner and in once. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0036 Specify: 3 DWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ elationship (Type. Print) 20b. Place of Disposition cemetery, crematory Pages ' 3 Removal from State 2 Cremation 5 ☐ Other (Specify) 21. Sintur f Funeral S York Pd. Craffiring 14.212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence **Examiner** Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No 24a. Was an certificate has b irector, page 2 s autopsy performe 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 29-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 5: 30 AM Charles Junior Shaffer JULY 21 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE HOSPITAL AGINES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 2, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1929 Days Hours Months 1√2 M 2□ F 79 Yrs Nov. Virginia 234-44-2116 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show Yes 2□No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 3300 Benson Avenue United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: If Yes, Give Year or Dates: 3 Widowed 4X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainmatic. Elementary/Secondary (0-12) 8th College (1-4or 5+) Steel Worker Tin Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida H. Auvil Charles Shaffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven M. Shaffer - Son 1221 Weddel Avenue, Arbutus, MD 21227 20c. Location - City or Town, State Date Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ** Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 7-25-2009 Baltimore, MD 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 12 DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trar Due to (or as a consequence of): aftending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. RENAL FAILURE 4 🗹 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?/ Ves 2 No 2 \ No of Vital 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? the Hospital or Attending I hin 24 hours after death. the Funeral Director; After Division 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

CHARL

SHAFFER

INTEALSIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAL,

32. Registrar's Signature

HOSPG

AGNES

29c. License number

D63305

29d. Date signed (Month, Day, Year)

07-21-2009

900 CATON AVENUE, MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month # **Physician** ames Eawarg \propto /Medical 4c. County of Death Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Date of Birth (Month, Day, Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Yrs. **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No by Funeral Director MA must be notific 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò USA 21239 Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 27 No Specify Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Mail Carrier 16b, Kind of Bu Tness/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Snowden Dennis If item 27 is marke or other traumatic ၉ Hilliam Lauretta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Belvedere Avenue, Ra Himore, Maryland 21212

position (Name of Date 20c. Location - City or Town, State permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trau once. Shivey E. Snowden 20a. Method of Disposition Baltimore, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Md 21. Signature of Funeral Service License Vork Rd. Butte. Md. 21212. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or healt failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** myo cardial /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 2 No 3 Probably 4 hiknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, page 1 Yes 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Internal 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24,2009 MO059540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of W	arylariu /		tificate of			-	grerii Reg. Ni	とせせう	2403	
ı			1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea	ath Da	ay Year	3. Time of Death	1
	Physici /Medio		William Stra	aughn						July 1		2009	8:08 PM	М
)	Examir		4a. Fecility Name (If not institution	n, give street and number)			4b. City, Town, o	r Locatio	n of Death		40	c. County of De		
			109 E. 33rd	Street			Balti							
	Funeral Director		5. Social Security Number unknown	YIYM 2006	ge (In yrs. last bi 74	Yrs.	Months Days	If Und Hours	Min.	8. Date of Birt (Month, Da 6 – 16 –		9. B 5 De	irthplace (State or Fore Country) laware	iign
	pur *		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Loc	ation						10d. Inside City Lim	ite
	f eho	5	MD		Baltir								XXYes 2 □	
	15e A	ect	10e. Street and Number		Darch	iiOI C	10f. Zip Code				10a C	itizen of What (Country?	
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	Jeath me 2:	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	/as Decedent of H Yes, specify Cubi	lispanic (Origin? (Spec	ify Yes or No			nerican Indian,	
2-003p	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 is marked other than "neturel", or Iteme 23s or 28e-f show other treumatic event, the Medical Examiner must be notilled at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes Give	? No		Yes, specify Cubi	Specific		lican, etc.)		Black, Wh Specifywh		
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and	be fi	Be	17. Father's Name (First, Middle,							(First, Middle,	Maide	n Sumame)		
Ž	ould J Mer nark	2	William Stua 19a. Informant's Name/Relations						llie					
M	d 2 sl th an 7 is r		Jeffrey Stra				Address (Street						, Zip Code)	
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pailimor	permit. Pages: Depertment of H Important: If ite any Injury or ot		1 ☐ Burial ★ Cremation 4 ☐ Donetion 5 ☐ Other (S	(pecify)		nt C	remato	ry	7-29-	-09		nover,		
Da	Depermine Deperm		21. Signature of Funeral Service	Licensee W	31328	Ch	Name and Addre	ss of Fac	Baltods Fu	timore un.Sv.	3 M.	D 2121 07Mond	6 lawmin Av	
NA N	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	ine.	of):	r the mode of dyir	ng, such a	as cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death Manager 2007	
J. DOX 00/00	To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d. 23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death		Ectopic pregnancy Other (specify)	′				23d. Date of d Month	elivery Day Year	
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	within To the	Ň	29b. Signature and title of certifie				29c. Licens	e numbe	r		29d. Da	ate signed (Mo	nth, Day, Year)	
				In Mh			Poo	333	30		7	122/20	09	
			30. Name and address of person	/	death (Item 23a)	(Type, P	Print) Sv: t	c 6	60	Baltu	M	pl. 21.	218	
	Sta Registr		31. Date filed (Month, Day, Year) JUL 28 2009	Server 32. Registr	ats Signature	Red								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 **Physician** July 25 7:45 A M Evelyn Jane Shipley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 X F 214-16-1894 Director 86 7-26-1922 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be neutified at once. 28a-f show MD Carroll Westminster 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 1330 Old Manchester Rd. 21157 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: white Completed by 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Edward Fowler Hilda Arnold ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vernon R. Shipley, Jr-son 1330 Old Manchester Rd., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Evergreen Mem. 7-28-2009 | Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home, P.A. 21. Signature of Funeral Service Licenses Plromat V. 254 E. Main St. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 3 \(\subseteq \text{ Ectopic pregnancy} \) Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) POUE HOUSE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To HOSPILE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division of Vital Records,

State

Registrar

Medical

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

700A pode pd WESTMINSPER AUBUMB COUPISHANK BR 31. Date filed (Month, Day, Year) 32. Registrar's Signature

4 Homicide

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 4:20 A. 25, Ju1y Kwan Woo Shin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 10750 Folkestone Way Woodstock If Under 1 Year Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 XM 2 □ F March 20, 1926 Korea Director 218-02-2359 83 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show 1 □Yes 2 No Woodstock <u>გ</u>Maryland Howard Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10750 Folkestone Way 21163 Korea Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Asian If Yes, Give Year or Dates: Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other trainmets. Elementary/Secondary (0-12) College (1-4or 5+) University Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Seung Hue Shin Τť. Ha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10750 Folkestone Way, Woodstock, MD. Min K. Shin (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify)

Meadowridge Memorial Pk

07/28/09 Elkridge, MD. 21075 22. Name and Address of Facility Gary L. Kaulman Funeral Home@ MMP, Inc 7250 Washington Blvd, Elkridge, MD 21075 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 21.57 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No signed by the a d be detached f 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ∐ Yes 2 🕱 No 3 Probably 4 Unknown nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

Year)

31. Date liled (Month, Day, Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



mi

			For State Registrar	State of Maryl		partment of F ertificate of			ene g. No.2	119	24034
			Decedent's Name (First, Middle, Las	1)			-	2. Date of Death	1	V	3. Time of Death
	Physicia /Medic			Edward	Spark			July	23,200		11:45A™
	Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County Anne		1.1
			North Arundel Hea 5. Social Security Number 6. Se		yrs. last birthda			8. Date of Birth	Anne		
ı	Funeral Director		255-44-1212	ÄM 2□F	76 Yrs.	Months Days	Hours Min.	Nov. 26,	Year) 1932	Geor	lace (State or Foreign try) gia
	ryland how	_	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or	Location				10	0d. Inside City Limits
	e Ma	Director	MD Anne Aru	ndel Co.	Glen B						1 □ Yes 2 No
	ith th	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of V		•
	s 23a	eral	504 Kent Circle	12. Was Decedent Ever i	5-11C 4	210		poif. Voc or No	United	Stat e - Americ	
	ter de item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armod Foreco?	In 0.5.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		ck, White, e	
3	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates: KO	rean	1 □ Yes 2 🕎 No	Specify:		Specify	Whi	te
	72 hor	sted	15. Decedent's Ed	ucation	16a. De	cedent's Usual Occupive kind of work done	pation during most of work		16b. Kind of Bu	usiness/Inc	lustry
1	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life	e. DO NOT use retire	d)	g	Wall	Corror	rinaa
4	led w tygiel her th		12 yrs.			Contractor	18. Mother's Name	o /First Middle N			Ings
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Millard Fillmon	e Sparks			The 1ma				
<u> </u>	shoul ind M mar umati	-	19a. Informant's Name/Relationship (7	ype. Print)	19b. Ma	ailing Address (Street	and Number or Rur	al Route Number,	City or Town,	State, Zip	Code)
,	and 2 lealth a m 27 is her tra		Mrs. Barbara B. S	Sparks /Wife	504	Kent Circ	cle Glen	Burnie,	Mary1a	nd 21	.060
,	of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Pomouni from State	Ob. Place of Dis	sposition (Name of rematory or other place	ce)	Date 2	20c. Location -	City or To	wn, State
	Pages ment of ant: If its ury or o		4 □ Donation 5 □ Other (Specify		Atlanti	c Cremator	cy July	25,2009	Glen	Burni	ie, MD
	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licen	see_	1121	22. Name and Addre		ngleton l	Funeral	. & C1	emation
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			23a. Part 1. Enter the disease, or composhock, or heart failure. List only	reations that caused the cone cause on each line.	death. Do not	enter the mode of dyli	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
Marie I	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Metas.	telic	591.1	Cell C	a g	line	1	3 NRS.
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	ficate be executed g physician and s the burial-transit	edical		d							
5	ding page as	/Mec	IF FEMALE:	23c. If yes, outcome of pro	egnancy				004 D	4	
3	eath certif attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су			te of delive onth	ery D <i>a</i> y Year
;	at the de by the stached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknown							
<u>.</u>	res that signed t be deta	by P	Part II. Other significant conditions of	ontributing to death but not	t resulting in the	e underlying cause giv	ven in Part I.	23e. Did tob	acco use conf	tribute to th	ne cause of death?
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ָב <u>ׁ</u>	law re las be 2 sho	Completed	HTA					24a. Was ar autops	24b.	Were auto	psy findings available mpletion of cause of
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110	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Licenite!		Cut		th (Check only one			
5	Physical dir	: To	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpa	tient 3 L DOA		ome 5 Reside			y)
5	ding Ph h. After thi funeral	tion	1 XNatural 5 ☐ Pending	(Month, Day, Yea		ry Wor	rk?]Yes 2 □No	28d. Describe no	w injury occur	reu	
2	Atten r deat sctor; by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm,			28f. Location (St.	reet and Numb	per or Rura	al Route Number,
5	tal or rs afte al Dire led in t	Certification:	4 ☐ Homicide determined	building, etc. (St	pecity)			City or Town	, State)		
	To the Hospital or Attending Physician: The law requires that the death certive within 24 hours atter death. To the Funcari Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a property filled in the funeral director.	Medical		ysician: To the best of my niner: On the basis of exa and manner stated.							
\	გ≱ნე	Ň	29b. Signature and title of certifier	handely	val	29c. Licens	se number	73 2	9d. Date signe	a (Month,	Day, Year) 2009
	10%		30. Name and address of person who a	completed cause of death	(Item 23a) (Typ	pe, Print) Bus	nie, h	rd. 2	106	1	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	-		·		-		
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2009 24035

		- For State egistrar				Certific	ate of	Death_					leg. No.	2 U		2400
Physicia		I. Decedent's Name (F	irst, Midd	le,Last)					-		2.	Date of Dea	ath Day	Year		ne of Death
edical Examin		Jai	lme L	eigh S _l	otts	wood						July 21, 2	2009			16 hrs
		a. Facility Name (if no	ot institutio	on, give street	and numbe	er)	4	b. City, Tov		ocation of	Death		1	unty of De	eath	
		Howard Count	ty Gene	ral Hospita	ıl			Columb	oia				How			
Funeral	7	5. Social Security Num	nber	6. Sex	7. A	ge (In yrs. last bii	rthday)	If Under		If Under			irth(MM/DD/	/YYY) 9. Foi	Birthplace reign	
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Aaryland 28a-f show 1 at once.	힐	10e. Street and Number		Owaru				10f. Zip C					10g. Citizen	of What C	Country?	
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ms 2	Funeral	11. Marital Status			as Decede med Force	ent Ever in U.S.	13. Was	s Decedent es, specify	t of Hisp Cuban,	anıc Origi Mexican,	Puerto R	cify Yes or Nican, etc.)		White, et		didit, Didox,
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	8	Rocky Spo											Espin		= .	
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	- 1	Judy Wall	ker-	Mother							CTTT		City, I			Chata
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		20a. Method of Dispos					e of Dispos atory or oth		e of cem	etery,		Date	20c. Loc	ation - Cit	ty or Town	, State
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only one)	Certifying Medical E	nysician: i xaminer:On t	ne basis of	examination and/	or investig	ation, in my	y opinior	n, death o	ccurred a	at the time, o	ate and plac	e, and due	e to the ca	use(s)
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09-05760 James Lee Saunders, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 24036

1. Decederating Model 1. Decederating 1. D			- For State Registrar		Cert	tificate of	Death					Reg. No.		
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The company of the control of the	/	Щ.		6 504	7 Age /In yrs la	est hirthday)			If Under :	24Hrs.	8. Date of B		/YYYY) 9.	Birthplace (State or
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State of Maryland / Department of Health and Mental Hygiene
Amend Items 26 per verb . g899.07/28/09dhb
Reg. No. 1 - State Registrar Reg. No. 🧶 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Monthuly Day :: 09:00AM **Physician** Violet L. Skoloda /Medical 4b. City, Town, or Location of Death 4c. County of Death. 4a. Facility Name (If not institution give street and number) Examiner Center 9. Birthplace (State or Foreign Country) WEst Virginia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 13, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Days 1 ☐ M 2 🂢 F 1925 83 235-28-7709 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination to Diffice at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ▼ No Towson Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 USA 7700 YOrk Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) department store cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Etta June McNair Jess Lee Blosser ۴ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2614 W. Woodwell Road Baltimore, MD Margaret S. Hughes/daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4Ĭ Donation 5 ☐ Other (Specify) 28 tareand Attate of Typilin Board 655 W. Baltimore Street Signature of Funeral Servi Pleasant Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRO VASCULAR ACCIDENT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) P.O. detached 9 ☐ Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 □Yes 2 🗷 No Division of Vital After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 Matural 1 □Yes 2 □ No death. 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the i 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D37254 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 BOON POH LIM M.D. 7601 OSLER DRIVE TOWSON. MARYLAND 32. Registra s Signature 31. Date filed (Month, Day, Year) State 28 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11:49 PM **Physician** 26 VIRGINIA THOMAS JULY P005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARBOR BALTIMORE LIOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday, **Funeral** 1 □ M 2 🗷 F 11/10/1915 Director 214-30-3529 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21061 110 Warwickshire Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐Yes 2 WNo 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Yes. Give Specify: Completed by White 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophie Mae Rapp Joseph Alfred Cavey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, MD 21122 <u>Joan Murphy / Daughter</u> 8542 Main Avenue, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Bayview Crematory 107/27/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 WEEKS SEPSIS disease or condition resulting in death) Due to (or as a consequence of): DIVERTICULITIS WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami WEFICS STROKE Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 □ Yes 2 1 No 9 Unknown 9 Unknown 2 Be Completed

Physician /Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Marked other than "natural", or items 23a or 28a-f show

er than "natura", the Medical F

item 27 is marked other traumatic ev

Baltimore, Maryland 21215-0036

items 23a or 28a-f show

g physician and attending p signed by the a certificate has been s rector, page 2 should Certification: To After thi within 24 hours after death

To the Funeral Director;
completely filled in by the

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Par	t I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
		24a. Was an autopsy performed? 1 □ Yes 2 □ NO 1 □ Yes 2 □ NO 1 □ Yes 2 □ NO
25. Was case referred to medical	26. Pla	ice of Death (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 I	Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year) 28b. Time of Work? Injury M 1 □ Yes 2 [28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Hornicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 ☐ Certifying I	'lysician: To the best of my knowledge, death occurred at the time, date iminer: On the basis of examination and/or investigation, in my opinion, d	and place, and due to the cause(s) and manner as stated. leath occurred at the time, date and place, and due to the cause(s)

29c. License number KES-000

5 State

Registrar

Medical

 $M \cdot D$.

29d. Date signed (Month, Day, Year)

26,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 SOUTH HANGUER STREET, BALTIMORE, MD. FERNAMOEZ

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 19b per th 8893 /-28-09 vt State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name, (First, Middle, Last) City, Town, or Location of Death If Under 24 Hrs. 8. Date of Birth 6. Sex Age (In vrs. last birthday 5. Social Security Number (M97/09/1908 BELARUS 1□M 2□ 081-05-5105 100 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No ANNAPOLIS ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 800 BESTGATE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No WHITE Specify: Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **BOOKKEEPER** LAW 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **EPSTEIN** AARON HANNA LEAH **ABRUTSKY** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 32040 CANTERHILL WESTLAKE VILLAGE, CA 91361 ERIC TAUB / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State BETH DAVID CEMETERY 07/25/2009 ELMONT, NY * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS... 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 0 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death monra Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ate of delivery Ionth Dav Year ntribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician /Medical

Examiner

10a State

MD

Funeral

Director

28a-f show

5

items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or Items 23a any injury or other treumatic event, the Manical Examiner mans once.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

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filled in by

Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consection of the consection	quelice of):			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 ⊟Ectopio	pregnancy (specify)		23d. Date of delivery Month Day Year
þ	Part II. Dther significant conditions	contributing to death but not re	sulting in the underlyin	g cause given in Part I.		use contribute to the cause of deat
Completed					24a. Was an autopsy performed?	
O	25. Was case referred to medical			26. Place of De	eath (Check only one)	
To B	examiner? 1 \sum Yes 2\sum No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: ursing	Home 5 Residence	6 ☐Other (Specify)
	27. Manner Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be determined		home, farm, street, fac	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number te)
Medical C		nysician: To the best of my kr miner: On the basis of examin and manner stated.				s) and manner as stated. nd place, and due to the cause(s)
M	29b Signature and title of certifier	1	0 1.0	29c. License number	29d. D	ate signed (Month, Day, Year)

31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

after death.

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To the

completely

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Рм 2009 3:20 24 Arthur Geatty van Reuth July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Blakehurst If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 96 Maryland 213-05-9905 September 25, Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Wedical Examiner must be natified at 1 ☐ Yes 2 🕱 No Director Towson Mary land Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21204 1055 West Joppa Road death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 🛛 No Specify: Specify: ş White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineering Professional Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia Aarand Edward Chester Karel van Reuth ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7819 Ballston Road, Ruxton, Maryland Department of Health a Important: If item 27 is any injury or other trainonce. Linda van Reuth / Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 07/30/2009 Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland, 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final weeks **Physician** 2000 as disease or condition resulting in death) /Medical Due to (or as a conjequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) physician and the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐Yes 2∐XNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. I Director: After id in by the funera Division 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print) BMC 6 3 Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Tul Year 6.01 AM **Physician** 009 Wells IVIAN 4a. Facility Name (If not institution, give street and number)

Halbitul of Baltimore /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Balti more If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday). Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Davs 1 □ M 2 🕶 F Months Hours 219-22-267 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10h County 28a-f show traumatic event, the Medical Examiner must be notified at 1 PYes 2 □ No Director MI timore 10g, Citizen of What Country? 10e. Street and Number ò USA 801 21201 items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban-Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland 17. Father's Name (First, Middle Last) Be andall ၉ 27 Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition Burial 2 ☐ Cremation 3 Removal from State 5 ☐ Other (Specify) 21. Sign re o Fune al Lervice Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Death 30 mm 0 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-t Due to (or as a consequence of) attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the at the detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes No page 1 ☐ Yes 2 ☐ No 1 □Yes of Vital 25. Was case referred to medica examiner? Be funeral director. 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 🗌 No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Kosbital of Baltimore 400 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 28 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 6:13AM **Physician** Weker 04 trederick OSEph /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltinoxe Rehabilitation Extended Care Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
9. Birthplace (State of Country)
Aug. 25,1920 Maryland 5. Social Security Number 6. Sex **Funeral** 1⊠M 2□F 220-09-9561 88 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show r than "natural", or itams 23a or 28a-f shov It e Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director Baltimore Maryland Baltimore City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 United States 3203 Independence Street deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: WW I I 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nn eny injury or other traumatic event, Ita Madione. College (1-4or 5+) Elementary/Secondary (0-12) Technician Pest Control 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be <u>Estella M. Guerke</u> William H. Weber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 825 West Middle Street, Hanover, PA 17331 Joseph Joyner/ Nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 217, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Baltimore, Maryland *4 Donation 5 Other (Specify)

Metro Crematory, Inc. 2009

Baltimore, Mary

21. Signature of Funeral Service Ligensee Amanda

Heast nz. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) unknown Dementia Pnysician Vasculor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the e 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cete hes been signe , page 2 should be d Š 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes Hospital or Attending Physician: 26 Place of Death Check on one 25. Was case referred to medical examiner? funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manufer of Death 1 Natural 28b. Time of After 5 Pending efter death. 1 🗌 Yes 2 🗆 No investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours e To the Funeral L 29a. Certifier Medicai 29b. Signature and title of certifier

BX.

State Registrar 31. Date filed (Month, Day, Year) JUL 28 2009

34359

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Bowlevard, Baltimore, Maryland 21218
32. Registrar's Signature 3900 Lock John S. Lah, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** Year ichae 09 /Medical a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, **Examiner** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 □ F Hours **Director** 213-60-9487 June 10, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examinat must be notified at Director 1 ☐ Yes 2X No Maryland Talbot Oxford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209 Tilghman Street 21654 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Yes. Give Specify Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sailor/ Artist Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John P. Williams Helen M. Gibson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa W. Wright/Sister 4346 Danlou Drive, Gwynn Oak, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. July 28, 2009 | Baltimore, Maryland 21. Signature of Juneral Service Licensee Aliama Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hor Tic /Medical resulting in death) Due to (or as a consequence of) Examiner 4100 a Sa In ntially in moliticing if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conseque ce of): Physician: The law requires that the death certificate be executer H7n and as the burial-tran Due to (or as a consequence of): Box 68760 physician Physician/Medical attending nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? Year Month 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed certificate Division of Vital I□Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 XYes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient After this funeral dir 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No the within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and a

31. Date

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 200 9 ware **Physician** 8. BA M en Leele /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number)
Good Samaritan Hospital 4b. City, Town, or Location of Death Examiner Baltimore 8. Date of Birth (Month, Day Feb. 12, 1943 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday, Social Security Number 6. Sex **Funeral** Days Hours Months Min. 219-40-9466 1 □ M 2XCX Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene. and the fire at 71 is marked other than "natural", or items 23a or 28a-f show ant. If item at 71 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, ht. Medical Express. Baltimore MD XF¥Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 USA 1416 Walker Avenue Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes XIX No If Yes, Give Year or Dates: 1 Never Married 2 Married _{Specify:}white Baltimore, Maryland 21215-0036 1 ☐Yes XX No Specify: þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Marie Corun Joseph Kramer ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1416 Walker Avenue-Baltimore, Maryland 19a Informant's Name/Relationship (Type. Print)
William Ward-spouse Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crownsville VA
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition

XX Burial 2 ☐ Cremation 3 ☐ Removal from State Date Crownsville, MD 7-28-09 4 ☐ Donation 5 ☐ Other (Specify) 8800 Harford Rd. Parkville MD 21234 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral and Cremation Chapel Services any in mouse LYYE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Io my o disease or condition resulting in death) 1600 /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Year Month Dav 5 Other (specify) P.0. 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 WUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No 1 □Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 **X** No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item) 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 560

31. Date filed Mg

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BlVd

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2009 9:30P. 25, Kenneth William Workman, Sr. July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County ESSEX 505 N.Marlyn Ave. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 16,1932 9. Birthplace (State or Foreign Country) Parsons, W.VA. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 11 M 2 □ F 77 Yrs. 216-28-5346 Director Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Evai: I wit must be notified at 1 □Yes 2KINd Director Maryland Baltimore County Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 United States 505 N.Marlyn Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11∑Yes 2□No If Yes, Give Norean Year or Dates Conflict 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Victory Racing Plate Machine Operator 03 N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phoebe DeMoss Clarence Workman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (SOII) Essex, Maryland 21221 505 N. Marlyn Ave. Mr.Kenneth William Workman, Jr. 20c. Location - City or Town, State July 29, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Loudon Park Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 21. Signature of Funeral Service Licensee 2 21093 2325 York Road Timonium, Maryland e. Complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Lift only one cause on each line. Approximate Interval Between Onset and Death 23a. Par | Enter the Iseas stron, or heart silure. Imme to Cause (Final disease or condition resulting in death) 1 Cancer Small cell Physician menths /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, is amy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent premant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year for 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the a s been signed b 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed certificate 2 🗆 No 1 ☐ Yes 2 ☑ No 1 □ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? After 1 V atural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified Suman 41 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUARE DRIVE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

09-05670 Edward Wolfe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 24046

			- For State	Cert	ificate of	Death			Reg. No.	
Ph ledical E	nysicia Exami	ın/	1. Decedent's Name (First, Middle,Las Edward Ellwood	Wolfe,				2. Date of Do Month July 20,	Day Year 2009	3. Time of Death 0310 hrs
			4a. Facility Name (if not institution, giv St. Agnes Hospital	ve street and number)		lb. City, Town, or Baltimore			4c. County of	N/A
	neral ector		5. Social Security Number 214-64-7303	ex 7. Age (In yrs. las	t birthday) Yrs	Months Day		Min	13 , 1955	g. Birthplace (State or Foreign Country) Maryland
ри	show any ice		Usual Residence of Decedent 10a. State 10b. County MD Carro		own or Locati	on eytown				10d. Inside City Limits 1 Yes 2 No
he Maryla	or 28a-f show ified at once	Director	10e. Street and Number 245 East Balti	more Street		10f. Zip Code	217 87		10g. Citizen of What United	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland	il", or items 23a or 28a-f sho ner must be notified at once	— L	11. Marital Status 1 Never Married 2 Marrier 3 Widowed 4 Divorce	1 Yes 2 No	1f Y	es, specify Cuba	n, Mexican, I o specify:	n? (Specify Yes or Puerto Rican, etc.)	White,	White
336 thin 72 hours a	of Health and Mental Hygjene. If item 27 is marked other than "natural", her traumatic event, the Medical Examiner	Completed b	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	during m	nt's Usual Occupations of working lif	e. DO NOT u	se retired)	16b. Kind of Bus	A
21215-0036 ould be filed within 7	ntal Hygier ked other ent, the M	Be Cor	17. Father's Name (First, Middle, Las Edward E. Wolfe,				Ka	athryn My	e, Maiden Surname) rtle Kess	ler
MD 21	th and Mer 27 is mar umatic ev	٩	19a. Informant's Name/Relationship (Dawn Wales Wolfe	e - Wife	245	E. Balt	imore,	, St., Ta	Number, City or Town	MD 21787
Baltimore, MD	ment of Health and Mental Hygiene. rant: If item 27 is marked other than ' or other traumatic event, the Medical		4 Donation 6 Other Specif	Removal from State At 1	ematory or ot	sition (Name of c ther place) Cremator Name and Addre	y ,	7-25-2009	Glen B	urnie, MD 1 Home, Inc.
	Department Important:		21. Signature The Service Line 23. Bart I. Enter the disease, or com	TOHOR	1 13	328 Sulp	hur Sp	oring Rd.	,Arbutus,	MD 21227
/Ms	sician I miner		failure. List only one cause on e	a. Multiple Injuries Due to (or as a consequence of			91			Between Onset and Death
		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):					
cuted	physician and the burial - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
760, cate be executed	/sician burial -	Medical	UNPENDED	AMENDED	20001				23d. Date of	delivery
Box 68760,	attending phy for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of pregring to the Live birth 4 Pregnant at time of de	2 F	etal death Sther (Specify)	3 Ectopic	pregnancy	Month	Day Year
P.O. B	ned by the	ρ	Part II. Other significant conditions		esulting in the	underlying caus	e given in Pa			ribute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O Ial or Attending Physician: The law requires that	has been sig 2 should be	Completed						a	outopsy performed?	Were autopsy findings available prior to completion of cause of death?
Rec The I	certificate	S	25. Was case referred to medical			26 Pla	are of Death	(Check only one)	es 2 No 1	Yes 2 No
/ital	nis certificate director, page	Be	examiner?	Hospital: 1 Inpatient 2 ✔	ER/Outpatier		Other ₄	Nursing Home 5	Residence 6	Other:
on of √	ath. rr: After th he funeral o	tion: To	27. Manner of Death 1 Natural 5 Pending		28b. Time of 0230 hrs		njury at Work	Operato	ribe how injury occur r of motorcycle	red involved in a collision
Division Atte	rs after death al Director: led in by the	Certification:	2 Accident Investig. 3 Suicide 6 Could not determine	ot be 28e. Place of Injury - At h		eet, factory, offic	e building, et	or To	ion (Street and Numb wn, State) Frederick Road , (per or Rural Route Number, City Catonsville , MD
Division of Vital Records, P.O. Box 68:	within 24 hours after death To the Funeral Director: completely filled in by the	ledical Ce	29a. Certifier	ician: To the best of my knowled her:On the basis of examination a and manner stated.	de death occ	urred at the time ation, in my opin	, date and pla ion, death oc	ace, and due to the curred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
D è	To To	Me	29b. Signature and title of certifier	withall min			ense number C.M.E.		July 20, 20	ned (Month, Day, Year)
			30. Name and address of person when Pamela E. Southall, MD			11 Penn Str	eet, Baltin	nore, MD 2120	1	
	S Regis	itate strar	31. Date filed (Month, Day, Year)		1. pa	Med				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 4:15 Am **Physician** MYRTLE LOU WELLS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BACTIMORE CATONSVILLE FREDERICK UILLA NSGEREHABICTR. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 😿 F 242-36-1747 North Carolina Apr. 8, 1929 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, tre Medical Extrainar must be retiffed at 1 ☐Yes 2 No Funeral Director Baltimore Baltimore MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21229 United States 324 Westshire Road Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give Completed by 3X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Summerland John Clinton Meeks ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 324 Westshire Rd., Baltimore, MD 21229 Svlvia D. Russell - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 7-26-2009 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Serv Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ADVANCED DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami USYPHAGEA burial-trai Due to (or as a consequence of) physician the burial Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 □ Yes 2 ⋈ No 1 ☐ Yes 2⊠No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

1 Natural 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

29a. Certifier (Check only one)

Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) AC 000647 07-23-09

Mingeli Rijest, CRP-F

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6905 MARSHLEE DRIVE, ELKRIDGE MD-21075

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 200 /Medical **Examiner** HIMORE 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months 1□M 2▼F Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f shordlcal Examiner must be notified at 1 Tes 2 No Funeral Director 1 timore 10e. Street and Number 10g, Citizen of What Country? ochwood Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married 1 Tes 2 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 🌠 No Specify: Completed by Widowed 4 ☐ Divorced Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natul any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 19b. Mailing Address (Street and Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pineral Service Licensee 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 212 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🎞 No Month Day Year 5 Other (specify) sate has been signed by the a page 2 should be detached it 9 Unknown 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 KQUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed State

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10: 50 PM July 2009 6 /Medical Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner moria 8. Date of Birth (Month, Day, 100 23 Under 24 5. Social Security Number 215-84-7534 Birthplace (State or Foreign Country) 7. Age (In yrs last birthday) If Under 1 Year **Funeral** Min 1 X 2 F Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Evanisher must be notified at 1 Yes 2 □ No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number ö 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: 3 Widowed 4 Divorced Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19b. Mailing Address (Street and Number or Rural, Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mothe 2914 303 E. 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22, Name and Address of Facility 3 e of Funeral Service Licensee 21. Signatu m. wallace ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disc shock, or heart failu Immediate Cause (Fin **Physician** sepsis days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner an Creatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Irrhosi Due to (or as a consequence of) Box 68760. Care Medical Certification: To Be Completed by Physician/Medical AIDS attending p for use as t IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Ye ar 5 Other (specify) P.O. I ed by the a detached f ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 INo 1 Yes 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 XInpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident death. 1 ☐ Yes 2 ☐ No after death completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 38946 2009 am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital, Danna Dorat Menorial Union 31. Date filed (Month, Day, Y State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene John Patrick Wolff, Jr. Certificate of Death 1- For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) John Patrick Wolff, Jr. Physician/ Month Day July 20, 2009 1117 hrs Medical Examine 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 507 East Clement Street 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number 216-54-1026 **Funeral** Foreign Country 3/25/50 MD 59 Days Director 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 XX Yes 2 No N/A MD Baltimore City 28a-f show or items 23a or 28a-f sho must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 507 E. Clement Street 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 XXNever Married 2 Married Yes White Air Forde Yes XX No specify: Specify If Yes, Give Year Divorced Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygene. natt. If item 27 is marked other than "natural", o nother traumatic event, the Medicial Examiner. Widowed ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) 12 College (1-4 or 5+ 0 Transportation MD 21215-0036 Taxi Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Williams Verna John P. Wolff, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 507 E. Clement Street, Baltimore Maryland 21230 Debra A. Wolff / Sister In-Law 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition timore, Burial 2 XX Cremation 3 Argent Crematory Removal from State 7/25/09 Hanover Maryland tment . Donation 5 Other Specify: haries L. Stevens Funeral Homme, Inc. 1501 East Fort Avenue, Baltimore MD 21230 21. Signature Funeral Service Licensee V1CTOr P. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and Death /Medical aAtherosclerotic cardiovasuclar disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cau e executed (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit AMENDED 23a,27,perm,E g894 8/11/09 TT Physician/Medical e attending physician a for use as the burial - t X UNPENDED The law requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown þ Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy s certificate has b rector, page 2 sh performed? death? 1 🗸 Yes No 2 ✓ Yes 2 he Rospial or Attending Physician: Th in 24 hours after ceath he Funeral Director: After this certifica pletely filed in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Other₄ Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 Inpatient 2 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural Yes 2 Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) Suicide determined (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier July 21, 2009 O.C.M.E. lovni (30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 OGME Melissa Brassell, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

ORIGINAL

			State of Maryland / Department of Health and I For State Certificate of Death Certificate of Death		ene g. No. 2009	24.051
r			Decedent's Name (First, Middle, Last)	2. Date of Death	1	3. Time of Death
	Physicia /Medic		Paul Daniel Wagner	July	24 2009	11:17 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Towson	1	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, March 13,	Year) 9. Bir	thplace (State or Foreign
١.	Director	,	202-24-2006 (W. 20 F) // Yrs.	March 13,	1932 Per	nnślyvania
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mary	ctor	Maryland Baltimore Baltimore County			1 ☐ Yes 2 🕱 No
	with the	Director	10e. Street and Number 710 Anneslie Road 10f. Zip Code 21212	10	og. Citizen of What Co U.S.A	
	death ms 23	Funeral	11. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Iral Midfiel Examinar must be neithed at once.	þ	Armed Forces? 1 Never Married 2 X Married If Yes 2 Y No If Yes, Give Ye ar or Dates: Armed Forces? If Yes, specify Cuban, Mexican, Puert 1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify:	o mican, etc.)	Black, Whit	nite
21215-0036	72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king	16b. Kind of Business	/Industry
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ylaı	ould b i Ment narked natic e	으	builter habeer hagher	on M. Kur		Zin Carla)
altimore, Maryland	nd 2 sh Ilth and 27 is n r traun		19a. Informant's Name/Relationship (Type. Print) Doris B. Wagner / Spouse 19b. Mailing Address (Street and Number or Relationship Road, Ba			21212
ore,	of Hea		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	
tim	tment tant: I fury o		4□Donation 5□Other (Specify)		Towson, Ma	
Bal	permil Depar Impor any in		Saulaia Penaie 1050 York Road, T.	owson, Ma	ryland 2	l Home, Inc. 1204
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar shock, or heart failure. List only one cause on each line.	c or respiratory arre	est,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			year
7	Examiner					0
J.	ed ed	iner	Sequentially list conditions, if any, leading to immediate cause. Enner underlying Cause (Disease or injury			
Jo.	execution and al-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
68760,	rificate be executed on physician and as the burial-transit	edical	d			
	ertifica ling ph e as th	Med	IF FEMALE:			
O. Box	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Other (specify)		23d. Date of de Month	Day Year
σ.	res that the de signed by the a be detached (Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	pacco use contribute t	to the cause of death?
rds	v requires been sign should be	ed by		1 □ Y€	es 2 ⊡ No 3 ☐ F	Probably 4 🗌 Unknown
Vital Records,	o — o	Completed		24a. Was a autops perforr 1 ∐Yes	y prior to ned2 death?	utopsy findings available completion of cause of s 2 □No
ita	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	ath (Check only on		1/
of V	ding Physician: The After this certification funeral director, it		1 ☐ Yes 2 ☐ No	Т	ence 6 other (Sp ow injury occurred	ecity) Hospice
	ling After fune	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 8b. Time of Injury 9cm M 1 Yes 2 No	200. Describe no	W Injury occurred	-
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town	reet and Number or F n, State)	Rural Route Number,
	e Hospital o 24 hours al e Funeral D letely filled i		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the o	ause(s) and manner	as stated.
	the Ho hin 24 h the Fui mpletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.			
	Voir Voir	Σ	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Mor	2009
			30. Name and address of person who completed cays of death (Item 23a) (Type, Print)		1017-1	
_	4		W.A. Riley (LBMC 6701 N. Charles St. Bal	to. md	2120/2	
	Sta Registi		31. Date filed (Month, Day, Year) JUL 28 2009 32. Figistrar's Signature A. Jack			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23b 25 27-28f per me 9929 77-9-12 vr. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Lewis Schaffer Whitcomb July 7:43 a^{M} Craig 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 19, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 X M 2 □ F Marvland 220-13-1935 24 1984 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ▼ No Baltimore Glen Arm Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21057 USA 12111 Manor Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🕱 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Diesel Mechanic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Whitcomb Deborah Lyons Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12111 Manor Rd. Glen Arm, Md. 21057 Mr. Lewis Whitcomb/ Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 又 Cremation 3 ☐ Removal from State Hilltop Service Co. 7-25-09 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses 23a. Part I. Enter the diseale, or commication of hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur I. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): Head Injuries with Complications Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last July to for as a nonsequence off CEPTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an perforn 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1X Yes EXIN 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Physician /Medical Examiner Examine

Department of Health a Important: If item 27 is any Injury or other trains

permit.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Experient mest be recified at

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Baltimore, Maryland 21215-0036

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2009

23,

attending physician and for use as the burial-tran signed by the atte peen has

Physician/Medical

Completed

Certification:

Medical

Records, P.O. Box 68760,

of Vital

CRAIG WHITCOMB

 Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate I To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

25. Was case referred to medical examiner?

Natural 2 Accident 3 🗌 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) 28b. Time of Nov. 18, 08 8:00 p

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2X No 28d. Describe how injury occurred subject driver of a car struck a tree 28f. Location (Street and Number or Rural Route Number, City or Town, State) Cub Hill Rd. near Cromwell Bridge Rd. Carney, Md.

Roadway Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one X Nurse Practitionermer stated. 29a, Certifier

29b. Signature and

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM.

31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 1 - For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer ° Physician 3:45 PM L. Widen 2009 15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 17350 Examiner Montgomes Friend's Assisted Living Sandy Spring Quaker Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 27, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Year) 1910 Months Hours 1 ☐ M 2 🛛 F 98 Kansas Director 512-26-0402 Usual Residence of Deceden death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show other traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 21 No Director Sandy Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20860 itams 23g 17330 Quaker Lane #E-15 Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: Specify: if Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk 1 and 2 should be filed within Health and Mental Hyglene. am 27 is markad other than ' College (1-4or 5+) Elementary/Secondary (0-12) journalist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Ingeborg Mattson Oscar Julius Widen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B 210 N. Leisure World Boulevard # 918 Silver Spring, Maryland 20906 19a. Informant's Name/Relationship (Type, Print) it of Health a: If itam 27 is Connie Peters/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ö 5 ☐ Other (Specify) 4 Donation 21. Signatur of Fun Jal Service Licensee ald S. Wade State Anatomy Board 655 W. Baltimore Street na Baltimore, Maryland 21201

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. -Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician . andiomus path /Medical Due (a) s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examine The law requires that the death certificate be executed burial-transit uamou and (a consequence of): Box 68760 physician Physician/Medical the attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy Month Day Year jo in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence ٩ 1 ☐ Yes 2 🗙 No 6 Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Diractor: After 5 Pending investigation 1 Natural death. 1 🗌 Yes 2 🗆 No 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined after 4 \(\text{Homicide} \) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 465

State Registrar

JUL 2 9 2009

JOHNMONEIL

31. Date filed (Month, Day, Year)

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

13978 Connectical Ave

Silver Spring

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 09-05802 Christopher Wade 1- For State Registrar 2. Date of Death

			Registrar								
	Physicia		1. Decedent's Name (First, Middle,	Last)					ate of Death lonth Day	y Year	3. Time of Death
Jedic	al Exami		CHRISTOPH	ER LEE	WADE			Jü	ily 24, 2009		2350 hrs
)		4a. Facility Name (if not institution,	give street and number)		4b. City,	Town, or Location	n of Death	1	4c. County of Deat	h
			Carroll Hospital Center			West	tminster			Carroll	
	Funeral				e (In yrs. last b	rthday) If Und	ter 1 Year If Ur	nder 24Hrs. 8.	Date of Birth(MI	M/DD/YYYY) 9. Bir	rthplace (State or
	Director		01 6 01 5001	1XM 2F	20	Monti	ns Days Hou	urs Min. S	ept. 19,	1988 Foreign	ountry) Maryland
	5110010.	- 1		1 M 2 F		Yrs.					
	>	- 1	Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Location					10d. Inside City Limits
	#										1 Yes 2 X No
	sho nce	ᡖ	Maryland Baltin	ore	паш	pstead					
)	Maryland 28a-f show any d at once,	Ş	10e. Street and Number			10f. Zi			10g. C	Citizen of What Cou	intry?
	ith the Maryland 23a or 28a-f sho notified at once.	Director	4814 Mount Carmel	. Road			21074			U.S.A.	
	hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must he notified at once		11. Marital Status	12. Was Decedent			ent of Hispanic C				rican Indian, Black,
	item item	Funeral	1 Never Married 2 Mar	rried Armed Forces'	No	If Yes, spec	ify Cuban, Mexic	an, Puerto Rica	in, etc.)	White, etc.	ite
	, or		3 Widowed 4 Divo	rced If Yes, Give Year	Ze No	1 Yes 2	No speci	ify:		Specify: WII	ite
	rs af ural min	þ	15. Decedent's Education (Speci	or Dates:	npleted) 16a	. Decedent's Usua			done 16b	. Kind of Business	/Industry
	illed within 72 hour Hygiene. d other than "natu	Completed	Elementary/Secondary (0-12)	College (1-4 or		during most of wo	orking life. DO NO	OT use retired)			
36	in 72 han "	읦	12	0		None	3			Special Ne	eds
8	led within Hygiene. other tha	팅	17. Father's Name (First, Middle, I	ast)			18.Moth	ner's Name (Firs	st, Middle, Maide	en Surname)	
5	filed Hy		James Francis Wa					Cynthia	. Jean	Robins	on
12	uld be fil Mental H marked c event, t	o Be	19a Informant's Name/Relationsh		- 14	9b. Mailing Addres	s (Street and N	lumber or Rural	Route Number,		
MD 21215-0036	shoul ond N is n	Ě	James F. Jr & Cynth							Yaryland 21	
Σ	s 1 and 2 s of Health a If item 27		20a. Method of Disposition			of Disposition (Na				c. Location - City o	
5	ages 1 and 2 shount of Health and Nt: If item 27 is nother traumatic		1 Burial 2 Cremation	3 Removal from St	ate crem	atory or other place	e)				
Ĕ	Page ment (4 Donation 5 Other Spe		Emory	U.M. Churc			_	Jpperco, Ma	ryland
Baltimore	prmit. Pag Department In portant:		21. Signature of Funeral Service I	icensee	/	22, Name an	d Address of Fac -Polyniak	Funeral	Home P A		
Ti.	1221	1	Tun S	1 Join	inn	1 +3() Fas	st Fort Av	enue.Kal	timore. M	arviand Zi	230
Р	hysician		23a. Part I. Enter the disease, or of failure. List only one cause of	complications that caused	the death. Do	not enter the mode	of dying, such a	s cardiac or res	piratory arrest,	shock, or heart	Approximate Interval Between Onset and
	Medical	1	Immediate Cause (Final disease	a. Complicat	ions of	perinat	al cereb	ral hy	poxia wi	ith	Death
	<i>i</i> xaminer		or condition resulting in death)	Due to (or as a cons	equence of): (erebral	palsy				
			Sequentially list conditions,	b							
		ē	if any, leading to immediate	Due to (or as a cons	equence of):						
No. in		Ē	cause. Enter Underlying Cause (Disease or injury that initiated	c Due to (or as a cons	aduana of:						
4	E &	Examine	events resulting in death) Last	Due to (or as a cons	equence or).						
1	ertificate be executed thing physician and se as the burial - transit	ल	▼ UNDENDED	AMENDED 23	a.27.pc	erME, g89	5 9/28/0	09 TT			
_	e be ex ysician burial	an/Medical	X UNPENDED							00 d D-4- of dollar	
68760	phy the b	Ž	IF FEMALE: 23b. Was decedent pregnant in the	e 23c. If yes, outco	me of pregnan		h 3 Ect	opic pregnancy		23d. Date of delive Month	Day Year
68	certific nding se as 1	ian	past 12 months?		t time of death	2 Fetal deat		opio progriario,			,
Š	atte for u	Sic	1 Yes 2 No 9 Unk	nown 9 Unknown		5 Other (Sp					
	the d	Physic	Part II. Other significant conditi		th but not resul	ting in the underlying	ng cause given in	Part I.	23e. Did tobac	co use contribute t	o the cause of death?
C	that deta	ē.		·					1 Yes 2	2 ✓ No 3 Pr	obably 4 Unknown
	urres n sig Id be	G	W 					- 20	24a. Was an	I 24b. Were a	autopsy findings available
	3 8 8 8	<u>=</u>	Į.						autopsy	prior to	completion of cause of
7	w r sbc	ı o.									
prord	he law rate has b	통	ļ <u> </u>						performed	No 1	Yes 2 No
Record	a: The law rufficate has b	Completed by	25. Was case referred to medical				26 Place of De	ath (Check only	performed 1 Yes 2		Yes 2 No
fital Record	sician: The law r is certificate has b lirector, page 2 sh	Be Comp	examiner?		ent 2 ✔ ER	/Outpatient 3	26 Place of De		performed 1 Yes 2 one)		
of Vital Record	Fhysician: The law retribites the certificate has been director, page 2 sho	: To Be Comp		Hospital: 1 Inpat	jury 28	/Outpatient 3 b. Time of Injury	Othor	Nursing H	performed 1 Yes 2 one)	No 1 V	
n of Vital Record	iding Physician: The law r h. After this certificate has be funeral director, page 2 she	ion: To Be Comp	examiner? 1 • Yes 2 No 27. Manner of Death	Hospital: 1 Inpat 28a. Date of In (Month, Day	jury 28		DOA Other	Nursing H	performed Yes 2 one) ome 5 Res	No 1 V	
eion of Vital Record	Attending Physician: The law refeath. ctor: After this certificate has by the funeral director, page 2 sho	cation: To Be Comp	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves	Hospital: 1 Inpat 28a. Date of In (Month, Day) stigation 28e. Place of	jury 28 Year)	b. Time of Injury	DOA Othery 28c. Injury at W	Nursing H	performer 1 Yes 2 one) ome 5 Res d. Describe how	No 1 V	
ivision of Vital Record	IN STORY OF STREET INCOME. I or Attending Physician: The law in a sher death. Director: After this certificate has be do in by the funeral director, page 2 she do in by the funeral director, page 2 she	rtification: To Be Comp	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Coult	Hospital: 1 Inpat 28a Date of In (Month, Day) 28e. Place of	jury 28 Year)		DOA Othery 28c. Injury at W	Nursing H	performer 1 Yes 2 one) ome 5 Res d. Describe how	No 1 V	er:
Division of Vital Records P O	UNISION OF VIGIL NECOLISIONS SPIRAL STREET OF ACCOUNTS After death. Ineral Director: After this certificate has by filled in by the funeral director, page 2 sho	Certification: To Be Comp	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could 4 Homicide	Hospital: 1 Inpat 28a. Date of In (Month, Day) stigation d not be mined Hospital: 1 28a. Place of (Specify)	year) 28	b. Time of Injury	DOA Other 2 28c. Injury at W 1 Yes 2 ry, office building	Nursing H Vork? 286 No No 281	performed Yes 2 one) ome 5 Res d. Describe how	sidence 6 Oth or injury occurred et and Number or F	er: Rural Route Number, City
Division of Vital Record	re Hospital or Attending Physician: The law n n 24 hours after death. The Funeral Director: After this certificate has be ideely filled in by the funeral director, page 2 should be the funeral director.	cal Certification: To Be Comp	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could 4 Homicide 29a. Certifier (Check only	Hospital: 1 Inpat 28a Date of In (Month, Day) 28e. Place of (Specify) To the best of	year) 28	b. Time of Injury , farm, street, factor	Other 2 28c. Injury at W 1 Yes 2 ry, office building the time, date and	Nursing H Vork? 286 No 281 No 281 Diplace, and due	performed Yes 2 one) ome 5 Res d. Describe how f. Location (Stree or Town, State	sidence 6 Oth injury occurred et and Number or F	er: Rural Route Number, City ated.
Division of Vital Record	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the fineral director, page 2 should be detached for use	edical Certification: To Be Comp	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could 4 Homicide 29a. Certifier (Check only one) 2 Medical Exam	Hospital: 1 Inpat 28a Date of In (Month, Day) stigation d not be mined (Specify) nysician: To the best of in miner: On the basis of ex and manner states	njury - At home	b. Time of Injury farm, street, factor death occurred at toor investigation, in	DOA Other 28c. Injury at W 1 Yes 2 Try, office building the time, date and my opinion, deatl	Mursing H Jork? 286 No 286 No 286 d place, and due h occurred at the	performed Yes 2 one) ome 5 Res d. Describe how f. Location (Street or Town, State of the cause(s) of time, date and	sidence 6 Oth	er: Rural Route Number, City ated. the cause(s)
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A Division of Vital Record		State	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Could 4 Homicide 29a. Certifier 1 Certifying Prone) 2 Medical Exam 29b. Signature and title of certifier 30. Name and address of person Russell Alexander MD 31. Date filed (Month, Day, Year)	Hospital: 1 Inpat 28a. Date of In (Month, Day) 28e. Place of (Specify) nysician: To the best of miner: On the basis of ex and manner stated who completed cause of Assistant Med	njury - At home my knowledge, amination and/	b. Time of Injury farm, street, factor death occurred at toor investigation, in I	DOA Other 28c. Injury at W 1 Yes 2 Dry, office building the time, date and my opinion, death 9c. License num O. C.M.E.	Mursing H Jork? 286 No 286 Jork? 286 Jork 286 J	performed Yes 2 Tone) ome 5 Resid. Describe how for Town, State to the cause(s) e time, date and	sidence 6 Oth injury occurred et and Number or F e) and manner as st place, and due to	er: Rural Route Number, City ated. the cause(s)

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

DOME

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** 01:14 AM 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Baltimore HOSPITA If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Months 1 □ M 2 👿 F 14-682 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modeal Eventual for notified at once. 1 ☐ Yes 2 V No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15300 UNITED Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 WNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MONKTON 5300 MANOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Buria! 2 ☐ Cremation 3 ☐ Removal from State SPRING CT 30,2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee YORK KOAU MONKTON SERVICES-MONITON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner theumonia Sequentially list conditions, and the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse quence of) Examiner attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 🗷 No o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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MODEN

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown

31 (24a. Was an autopsy

perform 1 ☐Yes 2 ☐No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 1∐Yes 2∏ÎNo

Heart Failure

27. Manner of Death 1 📈 Natural

2 Accident

3 Suicide 4 Homicide

6 ☐ Could not be

5 Pending investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital

28a. Date of Injury (Month, Day, Year)

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

HENUCCI, HD

29c. License number RES-000 29d. Date signed (Month, Day, Year) 07/25/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARIA B. HENUCCL - 6000 30 Manth

Loch Raven Blvd - Baltimore. 21286 - Haryland Hospital - 5601 31. Date filed (Month, Day,

State Registrar

been si

has

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division

Completed

Be

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Certification:

Medical

28 2009



DHMH 17 Rev 1/2001

	1 - For State Registrar	State of Marylan		rtment of H tificate of L			liene _{eg. No.} 200	19 24056
Physician /Medical		st)				2. Date of Deat Month July 12,		3. Time of Death 12:15 p M
Examiner	4		.age	4b. City, Town, or Silve	Location of Dea	th	4c. County of Prince	Death George's
Funeral Director	379-07-0274	6ex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 1916	Birthplace (State or Foreign Country) New York
hours after death with the Maryland tural", or items 23a or 28a-f show items in the putfled at the putfled at the Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Pr 10e. Street and Number	ince George's	y, Town or Loc	er Spring		1	0g. Citizen of Wha	10d. Inside City Limits 1 □ Yes 2 🏅 No
ath with	3152 Gracefield Roa				20904		USA	
within 72 hours after death with the Marylan jiene. I than "natural", or items 23a or 28a-f show the Medical Evaning out the multiple after completed by Funeral Director.	3 ⅓ Widowed 4 □ Divorced		2 -4 5	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 ☑ No lent's Usual Occupa	Specify:			American Indian, White, etc. White
Hygiene. Hygiene. other than "natura ant, the Medical E	(Specify only highest gra	College (1-4or 5+)	(Give I life. E	kind of work done of NOT use retired, rologist	lurina most of wo	orking		Government
ges 1 and 2 should be filed to f health and Mental Hygi If item 27 is marked other or other traumatic event, To Be Co	17. Father's Name (First, Middle, Last))			18. Mother's Na	ame (First, Middle, M bin	Maiden Surname)	
12 shout h and h and h ris mai	19a. Informant's Name/Relationship (Type. Print)		•		Rural Route Number		ate, Zip Code)
Pages 1 and nent of Health ant: If item 27 ury or other to	Douglas Arkin/Son 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.	Mot	lace of Disposemetery, crem	Macduff Average in the control of th	⁹⁾ Ju	ly 13.	d 20832 ^{20c. Location - Cit} Alexandria,	
permit. Pag Department Important: I any Injury o once.	21. Signature of Funeral Service Licer	isee Cala	F1 50	Name and Address rancis J. C O Universi	s of Facility Ollins Fur ty Blvd. I	neral Home : W., Silver	Inc. Spring, MD	20901
Physician /Medical	23a. Part 1. Ente the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line. Cardianyopathy a. Due to (or as a consequence)		er the mode of dying	g, such as cardia	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Pneumonia Due to (or as a consequ						
icate be executed physician and the burial-transit clical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Septicemia Due to (or as a consequ	ence of):					
ohysicia the bur		.d. Carcinoma of B	,					
r this certificate has been signed by the attending trail director, page 2 should be detached for use as: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of d	death 3	Ectopic pregnancy	·		23d. Date o Month	*
en signed to	Congestive Heart Fai	ontributing to death but not resu illure, Dysphagia	llting in the un	derlying cause give	n in Part I.		pacco use contribu	ite to the cause of death? Probably 4 💆 Unknown
has e 2						24a. Was al autops perforn 1 □Yes 2	y prio ned? dea	re autopsy findings available r to completion of cause of th? Yes 2 □ No
this certifial director		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	Othe	r.	eath <i>(Check only on</i> Home 5 ☐ Reside		(Specify)
tor: After this certificate the funeral director, pag	27. Manner of Death 1 🔀 Natural 2 🗋 Accident 5 📄 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	at		ow injury occurred	CP30iij)
ral Directial Direction by Certifi		building, etc. (Specify	"			City or Towr	n, State)	or Rural Route Number,
within 24 hours to the Funer completely fill	29a. Certifier 1 CertifyIng Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and place pinion, death occ	ce, and due to the courred at the time, d	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
	29b. Signature and title of certifier	Pathum	ana	29c. License	number D59524	2	9d. Date signed (A July 13, 2	
	30. Name and address of person who a Loveen Puthumana, MI				ing,MD 209	904		
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	-				

			1 - For State Registrar	State of Mary	yland /		rtment of F tificate of I			giene Reg. No	VIIII G	24057
ľ	Physicia	an	1. Decedent's Name (First, Middle, Las)					2. Date of De Month	Da	y Year	3. Time of Death
	/Medic	al	Thomas Edward And				4h Cihi Tourn oi	r Location of Death	July 1		2009 County of Death	2:30 A M
)	Examin	er	WMHSFrostburg Nu	,	ab Ce	nter	Frost				Allegany	
	Funeral	22	5. Social Security Number 6. Se	x 7. Age (I	In yrs. last i		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da			place (State or Foreign intry)
	Director		214-12-3501	S M 2□F 8	85	Yrs.	Months Days	Hours Min.	January			vland
	and w		Usual Residence of Decedent 10a. State 10b. County	10	0c. City, To	own or Loc	ation					10d. Inside City Limits
	Manyti f sho ied al	jo			Mann	4 Carro						1 Yes 2 No
	r 28a	Director	Maryland Allegan 10e. Street and Number			t Sava	10f. Zip Code			10g. Ci	tizen of What Cou	intry?
	th with		10809 Di	itch Hollow Roa	aci		21545-			U.S.	.A.	
	ems er mu	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. V		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Amer Black, White	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Merical Examiner must be notified at once.	by Fi	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 □ No If Yes, Give Year or Dates: ₩	WI	1	☐ Yes 2 No	Specify:			Specify:	
-00030	thour		15. Decedent's Edi	ucation		6a. Deced	ent's Usual Occup	ation		16b. K	Whi (ind of Business/l	
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7	ed wit ygjene er tha t, the	Com	12	0		Sextor	1				urch	
and	be filk d oth event	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam		, Maider	n Surname)	
3	d Mer marke	ို	Robert W. Andrews 19a, Informant's Name/Relationship (7)	inn Print)	1	Ob. Mailin	a Address (Street	Elizabeth I and Number or Ru		os Citu	as Tawa State 7	in Coda)
<u> </u>	id 2 slith an lith an traur		Anna May Andrews	wife			n Terrace		stburg		Marvland	21532-
a,	f Heal	1	20a. Method of Disposition				sition (Name of natory or other place		Date		ocation - City or 7	
altillio	Page: ient o nt: If		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Tellioval floil State			piscopal Cem		y 20, 2009	Moi	unt Savage I	Marvland
<u>=</u>	rmit. porta porta y Inju	li	21. Signature of Funeral Service Licens		Janu Ge		. Name and Addre		,,			118
0	89 = 88		John R.S	Level				al Home, 57			tburg, MD	21532
			23a. Part . Enter the disease, or comp shock, or heart failure. List only of	1	147	o not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Esopha	0		incer					2months
	/Medical Examiner		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Due to (or as a co	onsequenc	ce of):						
'n		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequenc	ce of):						
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
Ď,	e exectian an	Ex	resulting in death) Last	Due to (or as a c	consequenc	ce of):				,		
00/90	ficate be executed physician and is the burial-transit	edical		d							_	
	sertific ding p	/Mec	IF FEMALE:	23c. If yes, outcome pf	progpanov							
200	w requires that the death certil been signed by the attending should be detached for use a	Physician/M	in the past 12 months?	1 ☐ Live birth 2 [4 ☐ Pregnant at tim	Fetal dea	ath 3□	Ectopic pregnancy Other (specify)	y			23d. Date of deli Month	very Day Year
į.	the d ny the ached	ysi	1 □Yes 2 □ No 9 □ Unknown	9□Unknown	ne er dedir.		() () () () () () () () () ()					
Z.	s that ned b e deta	by Pt	Part II. Other significant conditions co	entributing to death but n	not resulting	g in the un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ecords	equire en sig ould b								1 🗆	Yes 2	2□No 3□Pro	obably 4 Unknown
S	law re as be 2 sho	Completed							24a. Was		24b. Were au	topsy findings available ompletion of cause of
<u>=</u>	The cate has page	Com							perf 1□ Yes	ormed?	death?	2XNo
N I I	iclan certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea				
5	ding Physician: The lav n. After this certificate has funeral director, page 23	. To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury		Outpatien b. Time of	3 DOA	4 Nursing H	ome 5 Res		6 ☐Other (Spec	cify)
	th. : Afte	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y		Injury	28c. Injur Wor M 1 □	rk? Yes 2∐No			,	
VISION	Atter er dea ector by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (- At home,	, farm, stre	eet, factory, office		28f. Location (ral Route Number,
5	tal or rs afte al Dir ed in	Cert	T L TIOTHOUGO	building, etc. (ореспу)				Only or To	m, otal		
	Hospi 4 hour Funer tely fill		(Check only 2 Medical Exam	/sician: To the best of r iner: On the basis of ex	xamination							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical	29h. Signature and title of certifier	and manner stated	d.		29c, Licens	se number		29d. D:	ate signed (Monti	n. Dav. Year)
			2 monsoch	Chia. MD)		por	55325		T	0, 15	2009
	5+		30. Name and address of person who	completed cause of deat	th (Item 23a	a) (Type, I	Print)		,	JV	mg , , ,	
	nold		29b. Signature and title of certifier **Noncelland** 30. Name and address of person who of the second sec	1 925 Bi	show	Wa	Ish Rol	Cumbe	rland	MD	21502	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	bars	1					
	Registr	ar	JOF TO 5008	Lever 1	10. 13							

DHMH 17 Rev 1/2001

			1 - For Amend	d Items 10	of Marylan	d/Dep per f	artmen rtificat	t of H	ealth, Death	87924	e/dalahk	giene) Reg. No.	009	24058
	Dhysisi	-	1. Decedent's Name (First, Mi	ddle, Last)							2. Date of De Month		Year	3. Time of Death
12	Physici /Medi		Oscar	Robe	rt		And:	rews			July	12	2009	10:25 P™
	Examir		4a. Facility Name (If not institu	tion, give street and nu	ımber)		4b. City,	Town, or	Location of	of Death		4c. Cou	nty of Death	
			Williamsport	Nursing Ho	me				sport			Was	shingt	on
	Funeral Director		5. Social Security Number 216–14–5978	6. Sex 1 M 2 ☐ F	7. Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Date Aug. 1	th ay, Year) 1, 192	Con	place (State or Foreign intry) 'yland
	pu:		Usual Residence of Decedent 10a. State 10b. Cour	2h/	10c Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	shoved at	5												1 ☐ Yes 2 ☐ No
	the N 28a-f	ect		ington		11iams	-	Codo				10g. Citizen	of Mhot Cou	Λ.
	with a or	Ö		0610 Bower	Avenue		10f. Zip							muy:
	s 23	eral	16909 Sterling		and ant Cuar in 11	LC 140		1795		ining /Cha	sift. Vac as Na		S.A.	ioon Indian
36	be filed within 72 hours after death with the Maryland that Hygiene. sd other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2□ N 3 ☑ Widowed 4 □ Divord	Armed F tarried 1 X Yes If Yes. G	2 ☐ No ive		was Deced If Yes, spec 1 ☐ Yes	cify Cuba	ın, Mexicar	n, Puerto	cify Yes or No Rican, etc.)	E	Black, White	, etc.
5-0036	2 hou atura cal E		15. Dece	lent's Education		16a. Dece	dent's Usua	al Occupa	ation			16b. Kind o	f Business/Ir	hite ndustry
15	n "n n "n Medi	Completed	(Specify only hig Elementary/Secondary (0-12	hest grade completed) (1-4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired	luring mos ')	t of worki	ng	ĺ		•
2121	filed within Hygiene. other than "	E	8	.) College	(1-401 5+)	Green	nskeep	per				Land	scapi	ng
ğ	should be filed nd Mental Hygi marked other matic event, tl	BeC	17. Father's Name (First, Midd	lle, Last)					18. Mothe	er's Name	(First, Middle			
Baltimore, Maryland	Suld be Mental arked o	To B	Robert Andre	ws					G1ac	lys M	l. Day			
ary			19a. Informant's Name/Relation			19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Numb	er, City or To	wn, State, Zi	p Code)
Σ	alth a 27 is 27 is r trai		William A. Sun	nan/Brother	-In-Law	1690	9 Ste	rlin	g Roa	ad. W	illiam	sport.	MD 2	1795
ē,	of Health a Item 27 is		20a. Method of Disposition		20b. I	Place of Dispo	sition (Nan	ne of	-		ate		on - City or T	
Ë	Page lent o nt: if ry or		1 X Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		i State	st Hav	-			7/16/	2009	Hagers	Storm	MD
Ħ	permit. Pages. Department of the Important: If Ite any injury or of other.		21. Signature of Funeral Serv		1.00		2. Name an				st Have			
ď	Depared Important Information		> S.Mund	& Sum						100	ve., Ha			
			23a. Part1. Enter the disease shock, or heart failure. I	or complication that	caused the deat								JWII, II	Approximate Interval Between
	Dhysisian		shock, or heart failure. I Immediate Cause (Final	ist only one course on	each line.	4000000	. A		/					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	(or as a conseq	way o	Wille	74	Chi	10a	SQ			-
	Examiner			Due to	(or as a conseq	quence oi).	01.							
hi		-	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a conveo	quence of):	ATTO						-1	
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	88/10	. ,							ų.	
en	be executed sician and burial-transit	xaı	that initiated events resulting in death) Last	c	(or as a conseq	uence of):								
8760,	be e siciar buris													
687	physi physi the l	dic		d										
×	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, or	utcome pf pregna	ancv						004	Data of dali	
Вох	atten for u	sian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	al death 3	☐Ectopic pr☐Other (sp					230.	Date of delive Month	zery Day Year
	at the de by the stached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unki		Jean 5L	_Other (sp	ecity)						
P.0	that t		Part II. Other significant cond	litions contributing to	death but not res	sulting in the u	nderlyina c	ause give	en in Part I		23e. Did t	obacco use c	ontribute to	the cause of death?
ds,	ires tha signed I d be det	by	Dialeto	1 Mollin	-	1)	+ 1	107	10-1	ic	1 🗆	NZ.		bably 4 Unknown
Ö	w require been sig should b	tec	10000	A leice	N() /	1-0	1-	100						
or Vital Records,	e law has b	Completed	New	algia,	1)0	ment	ia				24a. Was auto	psy	prior to co	opsy findings available ompletion of cause of
=	siclan: The certificate har rector, page	ខ្ល									1□ Yes	ormed? 2 ☐ No	death? 1 ☐ Yes	2□ No
ij	clan ertific ector,	Be	25. Was case referred to med examiner?							of Death	(Check only o	one)		
7	Physi this c	P.	1 ☐ Yes 200 No			ER/Outpatier			4) NU	rsing Hor	me 5□Resi	dence 6 □	Other (Spec	ify)
ū	ding P h. After t funera		27. Manner of Death 1 Matural 5 □ Pen	28a. Date ding (Mo	e of Injury nth, Day Year)	28b. Time o Injury	f 2	8c. Injury Work	/ at </td <td>2</td> <td>28d. Describe</td> <td>how injury oc</td> <td>curred</td> <td></td>	2	28d. Describe	how injury oc	curred	
<u>S</u>	Attending Physician: r death. ector: After this certifice by the funeral director, p	Certification:	2 Accident inve	stigation			М	1 🗆 '	Yes 2	No				
Division	or Att	ļ <u>ij</u>		ld not be ermined 28e. Plac build	e of injury - At he ding, etc. (Specia	ome, farm, sti	reet, factory	, office		2	28f. Location (City or To	Street and Nu wn, State)	ımber or Rui	ral Route Number,
	ital or rs aft	Ser												
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		ying Physician: To the cal Examiner: On the and ma										
	To the within 2 To the comple	Me	29b. Signature and title of cert	1			290	. License	number			29d. Date sig	gned (Month	, Day, Year)
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			20 Name and add	who led	Nuo	n 220) (T:=		,,,,,,,	,233			01	1141	12009
			30. Name and address of pers Shahid Mahm					lager	stow	n. MI	21742			
ą.	Sta	to	31. Date filed (Month, Day, Ye	ar) 32.	Registrar' Signa	ature _ al	/	501						
	Registi		JUL 28 20	09 Deneura	Registrar' Signa	gare	2							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15:45P JMPIthy 12, Day 2009 Year Sidney Blatt 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 A M 2 ☐ F 7. Age (In yrs. last birthday) Months Days Hours Min 08/26/1926 82 New York 129-16-8266 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count MD Montgomery Bethesda 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5225 Pooks Hill Road #521S 20814 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐Yes 2 X No If Yes, Give Ye ar or Dates: Specify: White Specify: 3 Widowed 4 Divorced WW II 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0wner Window Cleaning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna "Unascertainable" Morris Blatt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rosellin Blatt - wife 5225 Pooks Hill Road Bethesda MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Falls Churh, VA King David Mem. Gardns 7/14/2009 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockvillle Pike Rockville MD 20852 Mores 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAROTO PULMOVMY disease or condition resulting in death) Due to (or as a consequence of) CONONNY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Ye ar 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deals ABOUTENA INCMONOM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 7 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 \(\overline{No} 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 J/No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

burial-transit Attending Physician: The law requires that the death certificate be execu attending physician or use as the buria detached יסי מוש ביוויד יווידים After this certificate has been signed completely filled in by the funeral director, page 2 should be det Division of Vital Records,

e Hospital or Attending Physica 24 hours after death.

• Funeral Director: After this or

Physician /Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or Items 23a or

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic event, In Medical once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

2

the Maryland

Physician/Medical 2 Completed Be Certification: To

Medical

State Registrar 31. Date filed (Month, Day, Year)

JUL

14

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of pertifier

6 □ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 TELLO

and manner stated.

32 Registrar's Signat

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2009

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To the within 2.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician July 13, 2009 Palios Birdas 3:30 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 2824 Shanandale Drive Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 16, Birthplace (State or Foreign Country)
 Ohio 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2**⊠**F Months Days 79 Yrs 1930 296-26-9660 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County or Items 23a or 28a-f show event, the Modical Examiner must be notified at 1 ☐Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2824 Shanandale Drive 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 荃覧 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Public Highschool than College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education nit. Pages 1 and 2 should be filed vartment of Health and Mental Hygicortant: If item 27 Is marked other Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dimetri Palios Marie Casternoudi ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Birdas/Husband 2824 Shanandale Drive, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 16, permit. Page: Department o Important: If i any Injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 2009 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Ent.: the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or h. art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Ovarian Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Perneral Director: After this certificate has been signed by the attending physician and letely filled in by the furneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 🗌 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47612 July 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 104 Ridgely Avenue, Annapolis, MD 21401 Paul Macoul, MD 3. Registrar's Signatur 31. Date filed (Month, Day, Year) State 14

DHMH 17 Rev 1/2001

Registrar

Box 68760.

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** July 10, 11:00 Edwina Beall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Oct. 15, 1 If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 201 F California 86 Director 578-24-2839 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f show 1 ☐ Yes ŽŽNo Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 901 Arcola Avenue items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black. White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2√xNo Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: Specify þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 12 should be filed w h and Mental Hygie 7 Is marked other tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Anne Lenora Wells Frank Nelson Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pamela Campbell/Daughter 6375 Open Flower, Columbia, MD 21045 altimore. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State July 15, Crownsville, Maryland MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Inter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 days Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Advanced Dementia vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed for use as the burial-tran Due to (or as a consequence of): physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 5 ☐ Other (specify) signed by the a o. 9 Unknown 9 Unknown 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Hypertension, Failure To Thrive, Dehydration 1 ☐ Yes 2€XNo 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 certificate 1 ☐Yes 2 ☐No 1 □Yes 2 No of Vital Attending Physician; To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? __ Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1¹ Natural 28c. Injury at Work? Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide KScertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar Shyamsundar Rajan, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

29c. License number

9801 Georgia Avenue, Silver Spring, MD 20902

D53367

July 10, 2009

amend #17 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:50 AM July 10 2009 /Medical Ruth Ballard 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs Montgomery 3701 International Drive #653 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕇 F Months Min 93 July 9, New Jersey 421-40-5131 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show at a or 28a-f sho 1X Yes 2 No Director MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 US 3701 International Drive #653 items 23a must b Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 ☐ Yes 2 💆 No
If Yes, Give Examiner 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2K No 'natural", or Specify: **Black** If Yes, Give Year or Dates: þ 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Deputy Director Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Health & Social Service Federal Government 5+ permit. Pages 1 and 2 should be filed bepartment of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Booker Lonis C. Ballard Mary Hinton ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 812 Geranium St., NW Washington, DC 20012 Leonard W. Taylor / Son-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Chesapeake Crematory 07/15/09 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD. nsee 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service 7400 Georgia Ave., NW Washington, DC rances 20012 23a. Part1. Enter the dise se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failt e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 years Physician hronic /Medical Due to (or as a consequence of): **Examiner** Hyper tension 20 years Sequentially list conditions, if any, leading to infine under cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examine burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician pe Physician/Medical the as IF FEMALE: nse (23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year for in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No page 2 certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient မှ this funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fur death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D47654 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington DC 110 Irvingst, NW GB10 Dean, Mo lotte 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 14 2009 Registrar

DHMH 17 Rev 1/2001

/B.H. and in	an	For State Registrar AMEND#3cerM 1. Decedent's Name (First, Middle, Joanna Babest								2. Date of Dea Month	Day		3. Tirge of 355 ar -8:10 а м
/Medic Examin		4a. Facility Name (If not institution,	give street and nun	nber)	-	4b. City,	lown, or	Location of	Death	0.127		County of Deat	า
		Holy Cross Hospita	al					Spring				Montgom	
uneral irector		215-46-4531	6. Sex 1 □ M 2 1 F	7. Age (<i>In yr</i> s 85	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birt (Month, Da July 1,	h y, Year) 1924	9. Birt Co	hplace (State or Foreig untry) Greece
M.	1 F	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
-f sho	호	Maryland H	Howard		Ellicot	+ (4+1)							1 ☐ Yes 2 🖾 No
3a or 28a it be rroff		10e. Street and Number 8411 Church Lane			HELICO	10f. Zip		043			10g. Citiz	zen of What Co USA	untry?
r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🌥 Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 \to Yes If Yes, Giv Year or Da	ces? 2 ∑ No e		Was Deced		ispanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify. Whit	, etc.
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27 is rtra		19a. Informant's Name/Relationshi Andrea Babest/Daugh			1	-	•			Ott City		Town, State, 2 21043	?ip Code)
= =		20a. Method of Disposition			Place of Dispo cemetery, crea rt Linco					7 16, 2009		cation - City or Brentwoo	Town, State
Important: I any Injury o once.		21. Signature of Funeral Service L	icensee	200	2 F 5	2. Name an rancis 00 Univ	J. C versi	ss of Facility Ollins ty Blw	Fune:	ral Home Silver	Inc. Sprir	ng, MD 20	901
dical interpretation of the parial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last	b. Legion Due to (or as a conse	quence of):								
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stac	b	Part II. Other significant condition	ns contributing to de	ath but not re	sulting in the u	nderlying ca	use give	en in Part I.			obacco u Yes 2		the cause of death?
B	2									24a. Was autop perfo 1 □ Yes	an osy rmed? 2 \(\overline{\overline{1}}\) No	24b. Were au prior to death?	itopsy findings available completion of cause of 2 No
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i rector : After this certificate has been sign n by the funeral director, page 2 should be	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investige 2 Accident 6 Could not determin 29a. Certifier 1 Certifying	28a. Date of (Mont) ation of be 28e. Place	of Injury h, Day, Year) of Injury - At h ng, etc. (Spec best of my kr asis of examir	28b. Time of Injury	f 2 M reet, factory	Bc. Injury Work 1 office	er: 4 Nui y at ?? Yes 2 N	rsing Hon 2 do 2	ne 5 Resi	dence enow injury	y occurred d Number or Re	ural Route Number,
this certificate has been sign al director, page 2 should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investige investige 6 Could n determin 29a. Certifier 1 Certifying Check only 2 Medical E	28a. Date of (Mont) ation of be hed 28e. Place building g-Physician: To the building.	of Injury h, Day, Year) of Injury - At h ng, etc. (Spec best of my kr asis of examir	28b. Time of Injury	f M 2 M Preet, factory the occurred investigation	Sc. Injury Work 1 office at the tir in my o	er: 4 Nui y at ?? Yes 2 N	d place, a	ne 5 Resi	Street and cause(s) date and	y occurred d Number or Re	ural Route Number, s stated. to the cause(s) h, Day, Year)

DHMH 17 Rev 1/2001

		-	For State Registrar	State of Ma	aryland /		rtment of h tificate of				giene Reg. No.	7 11 1 1	24064
			Decedent's Name (First, Middle)	e, Last)						2. Date of De Month	ath Day	/ Year	3. Time of Death
	hysicia/ Medic/		Francis R	. Bodine	2					July	10	, 2009	5:00 a ^M
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, o					County of Death	
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	unerai rector		200-16-9108	1 X M 2□ F	85	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Date 07/01/	1924	Penr	nsylvania
70			Usual Residence of Decedent		T			-					101 1-11-01-11-
arylar	show	7	10a. State 10b. County		10c. City, To								10d. Inside City Limits 1 □Yes 2 ☑ No
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with	Sa or	Ö		0				653				S A	,.
death	ms 2:	Funeral Director	45525 Camelot 11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of F Yes, specify Cub		igin? (Spe	cify Yes or No		14. Race - Amer	
J35 urs after death with the Maryland	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination into the realised at once.	þ	1 ☐ Never Married 2X Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No		Yes, specify Cub	Specify.		rican, etc.)		Black, White,	white
5-0036 72 hours aft	natura lical E	Completed	15. Decedent (Specify only highes	t's Education	16	6a. Deced	ent's Usual Occup	ation	st of workir	na	16b. K	ind of Business/Ir	ndustry
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Maryland ZIZI: 2 should be filed within 7 h and Mental Hyglene.	mark	2	19a. Informant's Name/Relationsl		1	9b. Mailin	q Address (Street						
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ore,	item r othe		20a. Method of Disposition		20b. Place	e of Dispos	sition (Name of natory or other pla	ce)	D	ate	20c. Lo	ocation - City or T	own, State
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baltimor permit. Pages Department of	Import any inj once.		21. Signature of Funeral Service Kyle Simons	7.500	>		Name and Address Name 22955 Ho						
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused	d the death. B	-							Approximate Interval Between
Phys	sician	9 1	Immediate Cause (Final disease or condition	Alzh	eime	ers	Dis					1	Onset and Death
	edical miner		resulting in death)	Due to (or as	a consequence	ce of):	100000						
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DOX	been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea	ath 3	Ectopic pregnan	су			1	23d. Date of deli	very Day Year
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that t	ed by detac		Part II. Other significant condition	ons contributing to death b	out not resulting	g in the un	derlying cause giv	en in Part	1.	23e. Did	tobacco i	use contribute to	the cause of death?
COFGS, w requires t	n sign Id be	d by	Decubita	s ulse	r = S	Bacı	Rum			1 🗆	Yes 2	⊠ No 3□ Pro	bably 4 Unknown
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OT V Physic	his ce I direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/	/Outpatien	t 3 DOA Oth	ner: 4 🗆 N	lursing Hor	me 5 🛣 Res	idence	6 □Other (Spec	eify)
VISION OT VICAL RECORDS, P.O. BOX Of Attending Physician: The law requires that the death certifier death.	After this certificate has funeral director, page 2		27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of Inju		b. Time of Injury	28c. Inju Wor M 1 T	rk?		28d. Describe	how inju	ry occurred	
UIVISION I or Attending after death.	tor: / the i	icat	2 Accident investig 3 Suicide 6 Could i	not be	ury - At home	farm stre		Yes 2		28f. Location	Street at	nd Number or Ru	ral Route Number,
lor A after	Direct d in by	Certification:	4 ☐ Homicide determ	building, el	c. (Specify)	, 101111, 011	eet, factory, office			City or To	wn, State	e)	ar route remos,
To the Hospital or within 24 hours afte	To the Funeral Director: A completely filled in by the fu	Medical C		ng Physician: To the best Examiner: On the basis of and manner st	of examination								
o the	omple	Mec	29b. Signature and title of certifier		/		29c. Licen	se number			29d. Da	ate signed (Month	, Day, Year)
	7°		16	> In-h	7 1	UN	D00	00506			07	/10/2009)
b,	1000		30. Name and address of person	who completed cause of	death (Item 23	Ba) (Type, I	Print)						
1	U		Leon Berube,	9			age Rd.,	Mech	anics	ville,	MD	20659	
	Sta Registr	_	31. Date filed (Month, Day, Year)	2009 32. Fregisti	rar's Signature	1	all						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 11:25P M John M. Beckman July 5, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
4 Pennsylvania Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 197-14-9988 85 February 1,1924 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 □Yes 2 No Director Marvland ST. Mary's Charlotte Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 29449 Charlotte Hall Rd. 20622 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 ☐ No 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 🛚 No Specify: White Specify δ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Worker Steel Mill 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked othe any lighty or other traumatic event, other. 17. Father's Name (First, Middle, Last) Be Magnus Reinhold Beda Forsberg 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rebecca Kessler/Guardian 41780 Baldridge Street, Leonardtown, MD 20650 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Bynal 12 🖾 Cremation 3 ☐ Removal from State July 8 Brinsfield-Echols Crem. Charlotte Hall, MD 4 ☐ Conation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Brinsfield-Echols Funeral Home, PA I Service Lucensee 21. Signature of Funer M00817 30195 Three Notch Rd., Charlotte Hall MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a TYes 2 No o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Possible Myocardiac infarction autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Chronic obstructive Airway disease

25. Was case referred to medical examiner?

Hespital: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 26. Place of Death (Check only one) Hospital: 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭**X**No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 50653 7-15-2009 -anc

State Registrar

DHMH 17 Rev 1/2001

Surana, 5851 Deale Churchton Rd., Deale, MD 20751

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Bush 905 M Charles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegane Campus ('umber land Bradduck If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 84 207-22-8277 MO Director 12-14-1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Example contents to modified a once. Bedford 1 ☐Yes 2 ☑No HUNOMAN Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA HUNDMAN 15545 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 42 - 45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Completed by White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Kailroad Conductor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Bush SR. Mable ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3369 HYNOMAN MAMONPH Bush RD wife Hazel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Buria! 2 ☐ Cremation 3 ☑ Removal from State HUNDMAN Cemetery 7-11-09 HYNDMAN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hyndman PA 15545 Harvey H. Zeigler turural Home Irc 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRAtion **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. le Physician/Medical rene IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? performe certificate 2 1 No 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier D0066071

State Registrar

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TACIOODULA egistrar's Signature 900 Seton Drive, Comberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		For State Registrar	3	siale C	n war	yland / i		tificate				lental H	Reg. No	2011	3	240	57
Dhuaisis		1. Decedent's Name (First, Middle	e, Last)									2. Date of D			r	3. Time of Do	eath
Physicia /Medic		Betty			ane			Bean			-1 D 15	07	15	0	9	0950	М
Examin	er	4a. Facility Name (If not institution WMHS Braddoc			imber)			4b. City, To		1and	or Death			. County of De Allega			
Funeral		5. Social Security Number	6. Sex	1 2 💢 F		'In yrs. last bi		If Under 1			24 Hrs. Min.	8. Date of B (Month, L 10/24			Sirthpl	ace (State or I	Foreign
Director		220-34-1592 Usual Residence of Decedent			79		Yrs.					10/24	/1929) Mar	yla	and	
ryland ihow Lat		10a. State 10b. County			11	0c. City, Tow	n or Lo	cation	-						10	d. Inside City	
he Ma 28a-f s otifiec	Director		gany				Cu	mberla		-	_		10a Ci	tizen of What	Count	1 X Yes 2	
sa or 3		10e. Street and Number 951 Seton Di	cive,	Apt	4				215	02			Tog. Ci	US		uy:	
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s after	by Fu	1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced			2 X No ive			l∐Yes 2 j		Specify				Specify:			
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should be filed within 72 hours after death with the Maryland und Mental Hygiene. In a marked other than "natural" or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Completed	(Specify only higher	si grade d		1-4or 5+)		ife. L	DO NOT use	retired)	it or work	my		D-4-11			
filed v Hygie other t		12 17. Father's Name (First, Middle,	Last)				C	lerk	T	18. Moth	er's Nam	e (First, Middl	e, Maider	Retail Surname)			
uld be Mental arked o	To Be	George			Mas	on				Eva		Mae		(Unl	known)	
12 sho h and 7 is ma		19a. Informant's Name/Relations R. William Bean		· ·	n d									or Town, State			
tem 2		20a. Method of Disposition	, 11	uspai		20b. Place o	of Dispo	sition (Name	e of	1		Date	_	ocation - City		21502 wn, State	
Pages nent or int: If I		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		noval from	State			natory or oth Mem.			07/	18/2009	L	aVale,	MI		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modell Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	34	2 0	_ (•	Funera		•	. A .
90 F 8 9	-	23a. Part1. Enter the disease, or	complica	tions that	caused the	e death. Do								nd, MD	T 2	21502 Approximate	
∖ Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one	cause on	each line.	nonia				<i>3</i> ,		,				Onset and De	
/Medical Examiner		resulting in death)	(a	_		consequence									t	raing	>.
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eath certific attending p for use as t	sician/Medical	IF FEMALE: 23b. Was decedent pregnant	230			pregnancy □ Fetal deatl	h 3[∃Ectopic pre	egnancy	,				23d. Date of			
he dea the at	ysici	in the past 12 months? 1 □Yes 2 XNo 9 □ Unknown			gnant at tir	me of death		Other (spe						Month		Day Ye	ar
s that the de	by Phy	Part II. Other significant condition	ons contri	buting to d	leath but r	not resulting i	in the u	nderlying cau	use give	en in Part	l.	23e. Dio	tobacco	use contribute	to th	e cause of dea	ath?
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ding P		27. Manner of Death 1 Natural 5 ☐ Pendin investig		28a. Date (Moi	of Injury oth, Day, Y		Time of Injury	M 28	c. Injur Work	yat <br Yes 2 □	lNo	28d. Describe	e how inju	iry occurred			
Attendard death	Certification	3 ☐ Suicide 6 ☐ Could	not be	28e. Plac	e of Injury	- At home, fa	arm, str			163 2	,,,,,			nd Number or	Rura	l Route Numbe	er,
ital or ral Dir	Cert	4 Hornicide			ling, etc. (own, Stat				
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To the To the To the Compl	Me	29b. Signature and title of certifie	01	1.						e number			29d. Da	ate signed (Mo	onth, l	Day, Year)	
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MAS		30. Name and address of person	who com	pleted cau	p q	th (Item 23a) 25 B s Signature	(Type,	Print)	uls	h Ro	10	umbo	rlan	d mp	21	502	
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Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Mary		partment of H <i>ertificate of L</i>		-	giene Reg. No.	2009	24068
1	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
	/Media		Grace Jenning		iaw			July 1	.0, 2	009	8:05 P. M
	Examir	er	4a. Facility Name (If not institution, give				Location of Death			County of Death	
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	Funeral Director			M 2∏ F // Age (″	102 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 08/10,	iÿ, _{Year)} /1906	Coui	rginia
	aryland show	J.	10a. State 10b. County		c. City, Town or					1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	28a-f	Director	MD Anne Arun	idel	North	Beach 10f. Zip Code			10a Citiz	en of What Cou	
	with i	اق	617 California	Avenue		2071	1./4		_	.S.A.	tu y :
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinat must be notified at	Funeral		12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give	r in U.S. 1	3. Was Decedent of H If Yes, specify Cuba		pecify Yes or No Rican, etc.))- 1	4. Race - Ameri Black, White,	etc.
003	iours iral",	d by	3 M Widowed 4 □ Divorced	Year or Dates:						^{Specify:} whi	
21215-0036	2 should be filed within 72 h h and Mental Hygiene. 7 Is marked other than "natt fraumatic event, the Medic	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	16a. De (Gi	cedent's Usual Occupive kind of work done of DO NOT use retired	during most of work d)	ting		od of Business/In	
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Maryland	ld be lental ked c	To Be	Henry Jenn	nings			Annie	Estel	le	Knight	
ary	shou and N s mar umat	-	19a. Informant's Name/Relationship (Ty		19b. Ma	ailing Address (Street	and Number or Rui	ral Route Numb	er, City or	Town, State, Zip	o Code)
	1 and 2 Health a tem 27 Is		Robert C. Bradsha	w, son	795	Woodland W	Way, Owin	gs, MD	2073	36	
Baltimore,	permit. Pages 1 ar Department of Hee Important: if item any injury or othe once.		20a. Method of Disposition 1	lemoval from State		sposition (Name of rematory or other plac [ill Cemete		Date 5/2009		cation - City or To $tland$,	
Balti	permit. Pages 1 Department of t Important: If ite any injury or of once.		21. Signature of Funeral Service License	98		22. Name and Address 8325 Mt. H	Na			l Home,	P.A. 9736
			23a. Part Enter the disease or compli	cations that caused the	death. Do not			-		, 112 20	Approximate Interval Between
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1	/Medical		disease or condition resulting in death)	Due to (or as a co	ansequence of):		100-7	00.11			
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	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
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σ.	res that t signed by be detad		Part II. Other significant conditions con		ot resulting in the	e underlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
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<u>ö</u>	endir	atic	2 ☐ Accident investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Yes 2 □No				
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm, Specify)	street, factory, office		28f. Location (City or To	Street and wn, State)	d Number or Rur	al Route Number,
	To the Hospital or within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1 ☐ Certifying Phy: (Check only one) 2 ☐ Medical Exami	siclan: To the best of mer: On the basis of ex and manner stated	amination and/o	eath occurred at the tir r investigation, in my o	me, date and place opinion, death occur	, and due to the rred at the time	cause(s) date and	and manner as place, and due t	stated. the cause(s)
	To t With To ti	M	29b. Signature and title of certifier	noth of	7	29c. Licens	e number			e signed (Month,	
1.4	n (.		30. Name and address of person who co								
de	WI		Mukesh Mathur, M.		spital R	d., Suite	305, Pri	nce Fre	deric	k, MD 2	0678
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registratis	Signature	Janes!					
DHI	MH 17 Rev 1/2	001				11					

09-05414 James Paul Brown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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illies i aui biow	1-	For State	Certifica	ate of Death	Reg. N		7 2 700
Physicia	_	egistrar . Decedent's Name (First, Middle,Last)			Date of Death Month Day		3. Time of Death 1728 hrs
ledical Examin	-	James 6	Paul Bro	W M	July 10, 2009	18-11	17201113
	4	a. Facility Name (if not institution, give stre		4b. City, Town, or Location of D	eath	4c. County of Death	
		Route 50 & Backtown Road		Trappe		Talbot	
Funeral		. Social Security Number 6. Sex	7. Age (In yrs. last bir			Foreign	nplace (State or
Director		211 34 7785 IVM	71.	Months Days Hours Yrs.	Min. 19c+ 29		ary land
Bileotor	ć	(19-17-1700] =	4 / / /	113.	TOCHA!	,	
>	_	Jsual Residence of Decedent 0a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
w any		110 :- 11	1 +	0 0 N N 0		h	1 Yes 2 No
and sho	ō L	MD Talbo	1	10f, Zip Code	10g. G	Citizen of What Cour	itry?
A ULL death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	0e. Street and Number		101. 21p code	,	usa	
iii the N	ᄒ	3781-Ma	in Street	2/6/1	<u> </u>	- 0 /	can Indian, Black,
Z with S S S S S S S S S S S S S S S S S S S	Funeral	11. Marital Status	. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P	erto Rican, etc.)	White, etc.	carringar, black,
ast at the state of	킯	1 Never Married 2 Married 1	Armed Forces? Yes 2 No				. 10
e : e		3 Widowed 4 Divorced If	es, Give Year	1 Yes 2 No specify:		Specify: 3	ack
5-0036 Led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	황	15. Decedent's Education (Specify only h	ighest grade completed) 16a	Decedent's Usual Occupation (Give kir during most of working life. DO NOT us		b. Kind of Business/	industry
2 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			a - 1	<i>a</i>
136 hin 7 than than	힏	12		Supervisor	(OUTIER	COMPany
5-00 led wit tygien other	탉	17. Father's Name (First, Middle, Last)	0	18.Mother's	Name (First, Middle, Maio	den Surname)	
e file	B B	Samuel A	1. Brown	$\mathcal{A}_{\mathcal{D}}$	nie R.	JOHN	SON
21215-0036 uld be filed within? Mental Hygiene. marked other that	10 E	19a. Informant's Name/Relationship (Type		9b. Mailing Address (Street and Numb	1 4 . 4		e, Zip Code)
and and street		Pamela C	lay	1782 Wades Pti	Road McDo	Niel M	0,21671
	ŀ	20a. Method of Disposition	,	e of Disposition (Name of cemetery, atory or other place)	Date 2	Oc. Location - City o	r Town, State
MOFE Pages 1 Int of H Int: If i		1 Burial 2 Cremation 3			7/18/09	Trappe	· MD
imC Page ment tant: or ot		4 Donation 5 Other Specify:		dise Cemetery 22. Name and Address of Facility			, , , , , , , , , , , , , , , , , , , ,
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other th		21. Signature of Funeral Service License	3/2	Henry Funeka	1 Home, P.A.	l. ' d.o	MD-2/613
ш «д = .5		23a. Part I. Enter the disease, or complication	Severy	not enter the mode of dving, such as cal	diac or respiratory arrest	, shock, or heart	Approximate Interval
Physician		failure. List only one cause on each	III IC.	not officer the mode of Lyndy,			Between Onset and Death
V dical aminer		Immediate Cause (Final disease a. M	ultiple Injuries				1
.aiiiiiei		or condition resulting in death) Du	e to (or as a consequence of):				1
		Sequentially list conditions, b					
	ner	if any, leading to immediate Du cause. Enter Underlying Cause	e to (or as a consequence of):				
	Examine	(Disease or injury that initiated	e to (or as a consequence of):				
ted I I I I I I I I I I I I I I I I I I I	Ě	events resulting in death) Last d.					
60, ate be executed bhysician and re burial - trans	edical		AMENDED	· · · · · · · · · · · · · · · · · · ·			
60, ate be c physicia ne buria	edi	- Oliveria	23c. If yes, outcome of pregnan	CV		23d. Date of delive	ery
76 ficate g phy s the	ξ	IF FEMALE: 23b. Was decedent pregnant in the	1 Live birth	2 Fetal death 3 Ectopic	pregnancy	Month	Day Year
r 687 certifica ending p	iai	past 12 months?	4 Pregnant at time of death			1	
Box 687 e death certific the attending r	Physician	1 Yes 2 No 9 Unknown	9 Unknown				
). E the c by th	문	Part II. Other significant conditions	contributing to death but not resu	Iting in the underlying cause given in Pa			to the cause of death?
P.C S that gned e detz	<u>5</u>				1 Yes		obably 4 Unknown
S, quire en sig	ted			· · · · · · · · · · · · · · · · · · ·	24a. Was autops		autopsy findings available o completion of cause of
Orc IW reas be	ble				perforr	ned? death	?
Cec. The la ate h	Completed				1 Yes 2	No 1	Yes 2 No
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Be C	25. Was case referred to medical		26.Place of Death			hasi Caana
/ita /sicia nis ce direc	1 0	examiner?	spital: 1 Inpatient 2 Ef	R/Outpatient 3 DOA Other		Residence 6 🗸 Ot	ner: Scene
ing Physic After this	⊢	27. Manner of Death		Bb. Time of Injury 28c. Injury at Work	? 28d. Describe h Driver auto fi	ow injury occurred ixed object colli:	sion
on on one of the control of the cont	5	1 Natural 5 Pending	Jul 10, 2009 1	722 hrs 1 Yes 2 🗸	No		
VISIOR or Attend fler death Director:	Certification:	2 Accident Investigatio	28e. Place of Injury - At hom	e, farm, street, factory, office building, e	c. 28f. Location (S	treet and Number or	Rural Route Number, City
DIVI of in Ori	1 =	3 Suicide 6 Could not b determined	(Specify) Major Road		Route 50 & Ba	ate) acktown Road, Tra	ppe, Md
spitz hours nera		4 Homicide 29a. Certifier A Contifuing Physicis		the time date and pl	ace, and due to the cause	e(s) and manner as s	tated.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director	Medical	(Check only one) 2 Medical Examiner:	On the basis of examination and	or investigation, in my opinion, death or	curred at the time, date a	and place, and due to	the cause(s)
Fo th withi	edi	2 0 1110	and manner stated.	29c. License number		29d. Date signed (Month, Day, Year)
	Σ	29b. Signature and title of certifier		O.C.M.E.		July 11, 2009	
C		N-M					
7		30. Name and address of person who c	ompleted cause of death (Item 2	3a)	MD 04004		
V		Donna M. Vincenti, MD	Assistant Medical Exami	ner 111 Penn Street, Baltim	ore, MD 21201		
	Stat	31. Date filed (Month, Day, Year)	32. Registrar's Signature				
Regi		0.00 0.00 0.00	09 Bonna B	parket			
DHMH 17 Rev 1	1/2001		1	ORIGINAL			

For State Registrar

	Physicia		1. Decedent's Name (First, Middle, Last) Michael Edward Bledsoe, S	r.				2.	Month July,	Day	2009	3. Time of Death 3:05 p	
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 2441 Braddock Road		1	Town, or	Location of I	Death			ounty of Death		
	Funeral Director		5. Social Security Number 213-46-3275 6. Sex 1 M 2 F 7. Age 1 M 2 F 8. Sex 1 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M	(In yrs. last birth	nday) If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birth Month, Day, 12/08/1	949	9. Birthp Cour MD	place (State or Forentry)	∍igi
	e Maryland ia-f show	ctor	10a. State 10b. County MD. Carroll	10c. City, Town of Mt • A							1	0d. Inside City Lim 1 ∐Yes 2 🖔 I	
	h with the 23a or 28	Funeral Director	10e. Street and Number 2441 Braddock Road		10f. Zip 2:	Code 1771			10		n of What Cour J.S.A.	itry?	
036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the Modical Examiliar must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent 8 Armed Forces? 1 □ Yes 2 ☑ M If Yes, Give Year or Dates:		13. Was Deced If Yes, spe 1 ☐ Yes		spanic Origir n, Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No- an, etc.)		. Race - Americ Black, White, pec <i>ify:</i> Wh		
215-0036	ithin 72 ho ne. nan "natur Majical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary(Secondary (0-12) College (1-4or 5	+)	Decedent's Usu 'Give kind of wo life. DO NOT u	rk done d se retired	luring most o	f working			of Business/In-		
and 21	be filed Ital Hygi of other event, I	Be	10 17. Father's Name (First, Middle, Last) William Bledsoe	S	self-em	ploye	18. Mother's	Name (F	First, Middle, N hipe		structi urname)	on Co.	
Mary	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.	To	19a. Informant's Name/Relationship (Type. Print) Michael Bledsoe/Son	410	Mailing Address 07 Sequ	oia	Dr. We		nster,	MD.	21157		
saitimore,	Pages 1 al tment of Hee tant: If item jury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Disposition (Nai crematory or d iew Mem	oria	1 0	7/11	/2009		tion - City or To		
מם	permit. Depart Import any inj		21. Signature of Funeral Service Licensee		22. Name ai Burri 1212	er-Q West	ueen F Old I	uner iber	al Home	e & (Crematon	ry, P.A. MD. 2178 Approximate	34
	Physician /Medical		28a. Part1. Enter the disease, or complications that caused shock, or neart failure. List only one cause on each failure. List only one cause on each failure cause (Final disease or copdition resulting in death) Due to (or as	the death. Do not e.	ell (De or dyin		AM	espiratory arre	est,	•	Interval Between Onset and Death	5
	Heath certificate be executed a strending physician and after use as the burial-transit and	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of									_
O. Box 6	the death certific y the attending p ched for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Fetal death	3 ☐ Ectopic 5 ☐ Other (s _i	oregnanc	y			23	d. Date of deliv Month	ery Day Year	
ras, P.	quires that in signed by	δ	Part II. Other significant conditions contributing to death be	at not resulting in t	the underlying o	cause give	en in Part I.		23e. Did tob			he cause of death?	
II Records	The law re cate has bee page 2 sho	Completed						_	24a, Was an autops perform	y l	24b. Were auto prior to co death? 1 ∐ Yes	opsy findings availa ompletion of cause 2 □No	able of
or vital	Physician: this certifical director,	To Be		nt 2 ER/Outp			er: 4 ☐ Nurs	ing Home		ence 6[□Other (Speci	fy)	
DIVISION	To the Hospital or Attending Physician: The law requires that the dividing 42 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification:	27 Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28a. Date of Inju (Month, Da) 28b. Place of Inju (Month, Da) 28b. Place of Inju (Month, Da)	(, Year) Inj	М		yat (? Yes 2 ∐No		f. Location (St	treet and i		al Route Number,	
5	Hospital or 4 hours afte Funeral Dii tely filled in	edical Cer	29a. Certifier (Check only 2 Medical Examiner: On the basis o	of my knowledge, examination and					d due to the c	ause(s) a			
—	To the within 2 To the Comple	Med	29b. Signature and title of certifie	ned.	29	c. Licens	e number	31	2	9d. Date	signed (Month,	Day, Year)	
,	20		30. Name and address of person who completed cause of d	uth Ce	Type, Print)	She	et (<i>J</i> 60	SHINS	16	17031	157	
	Sta Registr		31. Date filed (Moorn, Day, Year) 32/Registra 10 2009	ar's Signature	pare								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		State of Maryland 1 - State Amended item#11,7.14.09,WCHI	/ Depa) , S E U r	rtment of He tificate of D	ealth and M eath		ene g. No. 20	09	24071
Physic		1. Decedent's Name (First, Middle, Last) Edward Arnold Brown				2. Date of Death Month July 4	Day	Year	3. Time of Death 5:50 a ^M
/Med Exam	iner I	4a. Facility Name (If not institution, give street and number) 314 Penn St。 5. Social Security Number 231-84-2701 6. Sex 7. Age (In yrs. las	4b. City, Town, or Location of Death Salisbury If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. 8.		8. Date of Birth 9. B		9. Birthpl Count	eath COMICO Birthplace (State or Foreign Country)	
Directo		Usual Residence of Decedent	Yrs.	cation		09/11/19	954		ginia Od. Inside City Limits
r 28a-f sh	Director	Maryland Wicomico Sa 10e. Street and Number	lisbu	10f. Zip Code		10	ng. Citizen of W	√hat Count	1 AYes 2 No
ath with	eral D	314 Penn St.		21801		-it-Wasseship	USA		- Indian
21215-UU36 Within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 2 ☑ Warried 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of His fYes, specify Cuban □Yes 2☑No	Specify:	Rican, etc.)	Blac	e - America k, White, e whi	tc.
d 21215-U	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Deced (Give I life. D	lent's Usual Occupat kind of work done du DO NOT use retired)	ion ring most of worki	ng 1	16b. Kind of Bu		
othe ent,	0	17. Father's Name (First, Middle, Last) Clarence Carr Brown			18. Mother's Name	(First, Middle, M			
, Marylan and 2 should be salth and Menta 127 is marked or traumatic ev	-	19a. Informant's Name/Relationship (Type. Print) Trudy Brown / spouse		g Address (Street ar Penn St.			-	State, Zip	Code)
ESILIMOTE, MATYIST permit. Pages 1 and 2 should be Department of Health and Menta Important: If iten 27 is marked any injury or other traumatic ev		1 Rurial 2 Compation 3 Removal from State	netery, crem	sition (Name of natory or other place, Cremator)	3/09	Salish	•	
permit. Departi		21. Signatur of Funciel Service Licensee	22	Name and Address Holloway 501 Snow	Funeral	Home Pro	ofession oury, M	nal A D 218	ssociation 04
Physiciar /Medica Examine		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to manediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Acla						Approximate Interval Between Onset and Death
icate be executed physician and the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	nce of):						
BOX eath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnance 1 Live birth 2 Fetal of 4 Pregnant at time of dead 9 Unknown Unknown Unknown 1 Example E	leath 3	Ectopic pregnancy Other (specify)				te of delive	ery Day Year
ecords, P.O. law requires that the das been signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death but not result	ing in the ur	nderlying cause giver	n in Part I.		oacco use cont es 2 ☐ No		ne cause of death?
The lar	Completed					24a. Was ar autops perform 1 🗆 Yes 2	v /	Were auto _l prior to cor death? 1 ∐Yes	psy findings available inpletion of cause of
OT VITAL Physiclan: 1 r this certificar ral director, pa	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien		26. Place of Deati		16.4	ner (Specif	v)
ION OT ending Phy ath. r: After this ne funeral di	I-	27. Manner of Death 11 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	28b. Time of Injury	28c. Injury Work?	at es 2 No	28d. Describe ho	ow injury occur	red	·
To the Hospital or Attending Piswithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)				28f. Location (St. City or Town	n, State)		
the Hospi hin 24 hou the Funer npletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination manner stated.		vestigation, in my op	inion, death occur	red at the time, d	ate and place,	and due to	the cause(s)
	-	29b. Signature and title of certifier M. O			0690		9d. Date signe		
100		30. Name and address of person who completed cause of death (Item 2) Janes E. MARTIN, M.D.	/ O O	E. C.	-011 57	. , 5-	1:56.	· >,	MD.
S Regis	tate trar	30. Name and address of person/who completed cause of death (Item 2) Jane 5 E. MARTIN M.D. 31. Date filed (Month, Day, Year) JUL 14 2009 Service	d. 4	lane					

09-05607 Eric Barnes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2009 24072

		Registrar Certificate C	Death	Reg. No.	3. Time of Death			
Physicia edical Exami	an/	Decedent's Name (First, Middle,Last) Eric Scott Barnes 2. Date of Death Month Day July 17, 2009 1720 hrs						
		4a. Facility Name (if not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Dea Hagerstown	n of Death 4c. County of Death Washington				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H	rs. 8. Date of Birth(MM/DD/YYYY)	9. Birthplace (State or Foreign Maryland			
Director		219-08-2864 _{1×M 2} F 27 Y	Months Days Hours M	June 2,1982	Country)			
ny		Usual Residence of Decedent 10c. City, Town or Loc 10a, State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits			
nd show a	ž	Maryland Washington County Smithsbu			1 Yes 2 XNo			
Maryla - 28a-f	Director	10e. Street and Number 11800 St Mary's Court	10f. Zip Code 21783	10g. Citizen of What	t Country?			
ith the 1	al Di	11 Mas Decedent Ever in U.S. 13.1	Vas Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue	Specify Yes or No- 14. Race -	American Indian, Black,			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 77 is marked other than "natural", or items 13a or 28a-f show any matic event, the Medical Examiner must be notified at once,	Funeral	1 XNever Married 2 Married Armed Forces? 1 Yes 2X No	White					
hours after 'natural'', o Examiner r	by	3 Widowed 4 Divorced If Yes, Give Year 1 15. Decedent's Education (Specify only highest grade completed) 16a. Decedenty 16b.	Yes 2 No specify:	Specify: of work done 16b. Kind of Busi	ness/industry			
136 hin 72 hour e. than "natu	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use r	etired)				
036 within 7 iene. er thar Medica	ldmo		truction Worker	Constructure (First, Middle, Maiden Surname)	ction Co.			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: I filene 27 is marked other than "Injury or other traumatic event, the Medical injury or other	Be Co	17. Father's Name (First, Middle, Last) Conway Stuart Barnes	Barbar	a Sue Warren Barr				
212 nould b	ToE	Too. Illustration of the control of		or Rural Route Number, City or Town	· · · · · · · · · · · · · · · · · · ·			
ore, MD 2 ss I and 2 shou of Health and M If item 27 is r her traumatic		20a Method of Disposition 20b. Place of Dis	position (Name of cemetery,	Smithsburg, MD 2	City or Town, State			
Baltimore, I permit Pages I and Department of Healt Important: If item injury or other tra		1 X Burial 2 Cremation 3 Removal from State Rest Ha	other place) ven Cemeterv 7-	22-2009 Hagersto	own, Maryland			
Baltimo permit. Pag Department Important:		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility	ouglas A. Fiery l	Funeral Home			
	/	23a. Part I. Enter the disease, or complication, that we sed the death. Do not ent		. North Hagerston or respiratory arrest, shock, or hea				
Physician /Medical		failure. Let only one cause on each line Immediate Cause (Final disease a. Narcotic intoxic			Between Onset and Death			
amine		or condition resulting in death) Due to (or as a consequence of):						
	je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of).						
760, icate be executed physician and the burial - transit		d. 23a 27 28a-	,perME, g893 7/3	30/09 TT				
30, te be ex sysician	n/Medical	IF FEMALE: AMENDED 23a, 27, 28a-1 23c. If yes, outcome of pregnancy	7, 0	23d. Date of	delivery			
68760, sertificate bo		23b. Was decedent pregnant in the 1 Live birth 2	Fetal death 3 Ectopic pro	egnancy Mo nth	Day Year			
Box e death c the attented for us	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)	- I - I - I - I - I - I - I - I - I - I	bute to the cause of death?			
ires that the death certinist signed by the attendin	Þ P		he underlying cause given in Part I.		Probably 4 Unknown			
rds, Frequires been sign	ted				Were autopsy findings available prior to completion of cause of			
e law requir e has been s	Completed			performed?	death? ✓ Yes 2 No			
of Vital Records, ag Physician: The law require ther this certificate has been s'	Be Co	25. Was case referred to medical	26.Place of Death (Cr					
F Vita Physici rrthis c	<u> </u>	examiner? 1 V Yes 2 No 27. Manner of Death Plospital: 1 Inpatient 2 V ER/Outpa 28a. Date of Injury 28b. Time	tient 3 DOA Other N of Injury 28c. Injury at Work?	ursing Home 5 Residence 6 28d. Describe how injury occurr	Other:			
on of \ nding Phy tth r: After tl	i di	1 Natural 5 Pending (Month, Day, Year) 1 Natural 5 Pending Investigation Fd 7/17/09 Fd 4	:40 pm 1 Yes 2X No					
Division tal or Attendins after death	ifica	2 Accident Investigation 3 Suicide 6 X Could not be determined (Court) found at r	street, factory, office building, etc.	28f. Location (Street and Numb or Town, State) 1180	er or Rural Route Number, City St. Mary's Ct			
The second discrete the council and manner as stated								
Fo the Hospital Within 24 hours	Medical	(Check only one) Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occur	red at the time, date and place, and o	due to the cause(s)			
F » F »	2 2	29b. Signature and title of certifier	29c. License number O.C.M.E.	July 18, 20	ned (Month, Day,Year) 009			
		30. Name and address at a rson and completed cause of death (Item 23a)	3.6					
OCN	/12	Mary G. Ripple MD. / Deputy Chief Medical Examiner	111 Penn Street, Baltimor	e, MD 21201				
Reg	Stat	1111 617 711110 2.60000	park					
No.C.								

	nded #23 phy., r	•	a)(b), , 07/13/0		Type or Pri				c. Ensure A Health and	-		_	
À116	gany Co		For State Registrar		State of M	ai yiaii	•	rtificate of		Mentarry	Reg. N	2000	24073
			Decedent's Nam	e (First, Middle, La	st)					2. Date of De	eath		3. Time of Death
	Physici Medi/		Tammy	Ī	Marie		Ce	cil		July '		ay Year 2009	5:45 P M
	Examir			-	e street and number))		4b. City, Town,	or Location of Deat	h	4	c. County of Dea	ith
1				oppy Str					berland				egany
	Funeral		5. Social Security N		Sex 7. Ag □M 2ਊ F	ge <i>(In yrs. la</i> 48	ast birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.	(Month, D	irth ay, Yea	9. Bir	thplace (State or Foreign ountry)
	Director		215-90-3	3430	Λ	40				05/09	9/19	b1Ma	ıryland
	yland how		10a. State	10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	e Mar ka-fs	cto	MD	Alle	gany		Cu	mberland					1 □Yes 2 No
	if the	Director	10e. Street and Nu	mber				10f. Zip Code			10g. C	itizen of What C	ountry?
	s 23a	al		Poppy S				215				USA	
	item item	Funeral	11. Marital Status	ied 2∏ Married	12. Was Decedent Armed Forces?	•	5. 13. }	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	0-	14. Race - Am Black, Whit	
936	urs af	5	3 Widowed		1 ∐Yes 2 ☑ If Yes, Give A Year or Dates:	110		1⊡Yes 2∏ No	Specify:			Specify:	White
21215-0036	2 hou	ted	(0	15. Decedent's Ed	lucation		16a. Dece	dent's Usual Occu	pation	-1.1	16b.	Kind of Business	
215	thin 7 ne. nan "n	Completed	Elementary/Seco	oify only highest gra endary (0-12)	Callege (1-4or t	5+)	life. l	OO NOT use retir	e during most of wo ed)	rking			
2	ed wi lygier ner th		12				F	ood Serv	T		<u> </u>		Schools
and	be fill Hall Had otl	a	17. Father's Name Earl	(First, Middle, Last,		Kette	nman		18. Mother's Nai		_		Duridan
Maryland	hould id Me mark matic	우		ame/Relationship (Ne o de l		a Addross (Strac	and Number or R			ona	Bridges Zin Code)
Σ	id 2 s Ith an 27 is			Cecil /					Street,				
ā	f Hea		20a. Method of Dis			20b. Pl	ace of Disno	sition (Name of		Date		Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Examination and Demotring an			☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State			natory or other pla lors Cam		15/2009	Be	eans Cov	e. PA
alti	permit. Departm Importa any Inju		21. Signature of Fu			1							L Home, P.A.
_	20189		Hele	uXU	ldan	/			ur Stree				21502
			23a. Part 1. Emer t shock, or hea	he disease, or com art failure. List only	plications that caused one cause on each li	d the death ine.	. Do not ent	er the mode of dy	ing, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause disease or condition	(Final	. MET	AST/	4TIC	LUN	G CA	UCER	,		Onset and Death
	/Medical Examiner		resulting in death)	•	Due to (or as	a consequ	ence of	OITH ME	TS TO	LIVERS	; Bra	ain)	
		je.	Sequentially list con if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	nditions, mediate	b Due to (or as	a consequ	ence of):		- <u>-</u>	N-j			
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60,	e exe sian a urial-t		resulting in death) I	Last	Due to (or as	a consequ	ence of):						
6876	rtificate b ng physic as the b	dica		•	d								
9 ×	certifi Iding se as	/Me	IF FEMALE:		23c. If yes, outcome	of pregnar	ncv					004 D-tf 4-	The same
Box	death cer attendin for use	ciar	23b. Was deceden in the past 12 1 ☐ Yes 2	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregnar Other (specify)	ncy			23d. Date of de Month	Day Year
P.O.	that the d ed by the detached	Physician/Medical	9 Unknown		9 ☐ Unknown								
	or Attending Physician: The law requires that the death certificate sifer death. Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	by P	Part II. Other signif	ficant conditions of	ontributing to death b	out not resul	Iting in the ur	nderlying cause g	iven in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
Vital Records,	v requir been s should	ted								1 🗆	Yes :	2 ∑ No 3□ P	robably 4 Unknown
ခ္ခ	e 2 sh	Completed							•	24a. Was	DOSV	24b. Were a	utopsy findings available completion of cause of
<u>=</u>	ician: The l certificate ha ector, page									pent 1 □ Yes	ormed? 2 L	death? lo 1 ☐ Ye	s 2□No
	siclar certif	Be	25. Was case reference examiner? 1 ☐ Yes 2 ☑		Hospital:			01	26. Place of Dea				
of	ding Physician: n. After this certific funeral director,	7: To	27. Manner of Deat	-	28a. Date of Inju		ER/Outpatier 28b. Time of	1 0 0 00 A	4 🗆 Nursing r	28d. Describe		6 ☐Other (Speury occurred	ecify)
io	nding ath. r: Afte e fun	aţi.	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		ıy, Year)	Injury		rk? ⊒Yes 2.⊒No				
Division of	after death after death Director: d in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj	ury - At hor	me, farm, stre	eet, factory, office		28f. Location City or To	(Street a	and Number or R	ural Route Number,
	italo Insaft ralDi												
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)		ysician: To the best niner: On the basis o and manner st	of examinati							
	within To the compl	Me	29b. Signature and	title of certifier				29c. Licer	se number		29d. D	ate signed (Mon	th, Day, Year)
	2.		► M\	= N.Q0	wirmi	1		D	0064167		Jul	y 13, 2	009
	NUT NAS		Nosh	ess of person who in Qaisra	completed cause of dani, M.D.,	th (Item 500	Memor	rial Ave	nue, Cumb	erland,	MD	21502	
	Sta Registr	te ar_	31. Date filed (Mon	th, Day, Year)	32. Registr	rar's Signati	bare	w					
					Marian	La.	1						

1. Decedent's Name (First, Middle, Last)

Cleo

Maxine

Physician

4a. Facility Name (If not institution, give stre	eet and number)		4b. City,	iown, or	Location	n Dealli		40	. County of Deal	ui
WMHS-MEMORIAL CAMPI	IS			BERL				A	LLEGANY	
Social Security Number 6. Sex	7. Age (In yrs. last birthday Yrs.	Months	Days	If Under: Hours	Min.	. Date of Birtl (Month, Day 2/01/1	y, Year)	Co	thplace (State or Foreign ountry) TYland
Usual Residence of Decedent										I dod Incide City Limite
MD 10b. County Allegar		0c. City, Town or L	ocation Cumbe	rlan	ıd					10d. Inside City Limits 1
10e. Street and Number			10f. Zip	Code				10g. Ci	tizen of What Co	ountry?
101 Massachuse	tts Avenu				21502				USA	
11. Marital Status	Was Decedent Event Armed Forces?	er in U.S. 13.	Was Dece If Yes, spe	dent of H cify Cuba	ispanic Ori an, Mexican	gin? (Speci , Puerto Ric	fy Yes or No- can, etc.)		 Race - Ame Black, White 	
1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ⅓No If Yes, Give Year or Dates:		1 □Yes	2∏No	Specify:				Specify:	White
15. Decedent's Educat (Specify only highest grade c		(Give	edent's Usu e kind of wo DO NOT u	rk done d	during most	t of working		16b. k	Kind of Business	/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		ceivi						Retail	1
17. Father's Name (First, Middle, Last)			_		18. Mothe	er's Name (/	First, Middle,	Maider	n Surname)	
Herman	Joseph	Curry			Eli	zabet	h	Alm	eda	Ruppert
19a. Informant's Name/Relationship (Type Clifton J. Cook / H									or Town, State, . rland, I	
20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Ren	noval from State	20b. Place of Disp cemetery, cre	osition (Na	me of	e)	Dat	е	20c. L	ocation - City or	Town, State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servide Licensee		Hillcres				7/22/			umberlan	nd, MD 1 Home, P.A.
21. Signature of Funeral Service Licensee	ans	I						-	nd, MD	•
23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	tions that caused the cause on each line.	e death. Do not er	nter the mod	de of dyin	ng, such as	cardiac or I	respiratory ar	rrest,		Approximate Interval Between Onset and Death
disease or condition resulting in death)	men	mone	. 63-							Cherry
	/Due to (or es a c	onsequence or):								9
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injusted exercises)	Due to (or as a c	onsequence of):								
that initiated events c. resulting in death) Last	Due to (or es e c	onsequence of):								
d										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No	. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death 3	□ Ectopic p						23d. Date of de Month	elivery Day Year
9 ☐ Unknown							T			
Part II. Other significant conditions contri	butin g to death but r	not resulting in the	underlying o	ause giv	en in Part I.					o the cause of death? Probably 4 Unknown
1							24a. Was	an	24h Were a	utoney findings available
						-	autop	sy rmed?_	death?	utopsy findings available completion of cause of
25. Was case referred to medical					26. Place	of Death (Check only o			
examiner? 1 ☐ Yes 2 ☑ No	pital: 1 Inpatient	2 ER/Outpatie	ent 3 D	OA Oth	er: 4 🗆 Nu	ursing Home	e 5 Resid	dence	6 ☐ Other (Spe	ecify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Y	(ear) 28b. Time (Injury	of M	28c. Injur Worl	yat k? Yes 2□		d. Describe h	now inju	ury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, si (Specify)	treet, factor	y, office		28	f. Location (& City or Tow	Street a	nd Number or R le)	Rural Route Number,
29a. Certifier (Check only one) (Check only one)	r: On the basis of ex	kamination and/or i								
29b. Signature and title of certifier	and manner state	J.	29	c. Licens	e number			29d. D.	ate signed (Mon	th, Day, Year)
Surger	alkin	-		4411			J	Ju1y	19, 20	09
30. Name and address of person who com Beverly Cal				ial	Avenu	e. Cur	mberla	nd.	MD 21	502
31. Date filed (Month, Day, Year)	2. Registrar's		Med			,		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Cook

Reg. No.

Day

17

Year

2009

1240

2. Date of Death

07

State Registrar

5 nas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Gordon L. Collins July 2009 3:15 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) Days Months Hours Min. 1 □ M 2 □ F 69 13 1939 Trinidad Director 592-70-6731 oct. Usual Residence of Decedent 10d. Inside City Limits with the Maryland f show 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f shove event, its Medical Evanting institution 1 ☐ Yes 2 No Director Carroll MD Manchester 10g. Citizen of What Country? 10e. Street and Number 2698 Mount Ventus Rd. No. 21102 Trinidad death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: black 2 3 ☐ Widowed 4 🖾 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ite. Monee. Elementary/Secondary (0-12) College (1-4or 5+) musician entertainment 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lionel Hugh Collins Gertrude Florence Fletcher ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2.1102 19a. Informant's Name/Relationship (Type. Print) Harry E. Collins, brother 2698 Mount Ventus Rd. No. Manchester, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 7/10/2009 Hampstead, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home M00741 Semm 934 S. Main Street, Hampstead, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chiline. Immediate Cause (Final neumonis **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** tailure. ngerhive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Hinthown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy performe certificate 1 ☐ Yes 2 NN 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Thpatient Certification: To this funeral 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and Name and address of person who completed cause of death (Item 23a) (Type, Print)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 9 Man

Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2009 rnard /Medical County of Death City, Town; or Location of Death Facility Name (If not institution, give street and number) Examiner INCE Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** M 2 F Months Days Hours Min. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertial Hygiene.
ant: If lem 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, I'm Medical Examinat must be notified at ury or other traumatic event, I'm Medical Examinat must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 □ No Funeral Director TOYC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2012 -401 12. Was Decedent Ever in U.S.
Armed Forces?.
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. IDO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 0 NOW la Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaini Department of Health Important: If Item 27 any Injury or other transmission. Carrollton 20b. Place of Disposition (Name of cemetery, crematory or other place) - City or Town, State 20a. Method of Disposition Date 3 Removal from State Burial 2 Cremation -15-2009 aid 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur s of Funeral Service Licenses Morn sette VINONA Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on a 1 line. Do not enter the mode of dying, such as cardiac or respiratory arrest, mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Tyes 24 hours after death. Funeral Director: A in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide completely filled 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated within 2 To the To the

Registrar

31. Date filed (Month, Day, Year) 1 5 2009

29b. Signature and title of certifie

30. Name and address of person

ANNAMOIS aru 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

State

29c. License number

26

29d. Date signed (Month, Day, Year)

JA06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Coleman Burgess Α. July 2009 1308 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) Months 1 X M 2 □ F 10-15-1929 Pennsylvania 172-22-8141 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Washington DC 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20003 USA 1827 Independence Ave SE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmaceutical Technician Merck Pharmaceutical 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Stanford Burgess A. Coleman Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Independence Ave Wash, DC 20003 Sarah Coleman (Wife) 1827 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington Virginia ArlingtonNatCemet 08-05-09 4 Donation 5 Other (Specify) 21. Signature of Funcial Service Liouviee 22. Name and Address of Facility wash, DC Tyrone J. Young 719 Kennedy St.NW mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one dause on each line. 23a. Part / Enter the disease, or com shock or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final ULMONARY disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last SEIZUNE Due to (or as a consequence of): HYDERTENSION IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24at Was an autopsy OF TOM 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 | Yes 2 | No 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner Division of Vital Records, P.O. Box 68760.

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar certificate has be irector, page 2 sl director this funeral after death Director: / within 24 hours aft

To the Funeral Di

completely filled in To the I within 2 To the I

Physician

Examiner

Funeral

Director

28a-f show

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items 23a

"natural", or

event, the Medical

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, IT. Maone.

Physician

/Medical

Exaciling thust be notified at

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification: To

Medical

State

29a. Certifier

(Check only one)

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

Registrar

SHALLID SHAMIM, M) 31. Date filed (Month, Day, Year) JUL 1 5 2009

WARHINGTON ADVENTIST HOSDITAL, TAKOMA PARY MD-20912 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ye ar **Physician** 009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🕱 F 578-46-0086 Yrs 75 25, Sept. 1933 **Director** DC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I've Medical Evantar must be notified at 1 XYes 2 ☐ No Director DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20010 3322 14th Street NW United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or ite 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 African 1 ☐ Yes 2 ☑ No Specify: ģ 3 X Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Caterer Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Blackwell James Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1817 Bay Street SE 20003 Jerome Young/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/21/09 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Si nature of Funeral Service License 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical 200 Partive Rade Caeterenia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed signed by the attending physician and I be detached for use as the bunal-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 \(\subseteq \text{ Ectopic pregnancy} \) in the past 12 months? Month Day 5 ☐ Other (specify) 1 ☐ Yes 9 ☐ Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ been s Completed 24a. Was an

Division of Vital Records, P.O. Box 68760. page 2 should has funeral director, After Hospital or Attending 24 hours after death. after death. To the Hospital within 24 hours a To the Funeral

Be

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Certification:

Medical

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Impatient 2 ER/Outpatient 3 DOA 4
Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day, Year) 28c 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 ☐ Accident 6 Could not be determined 3 Suicide

29a. Certifier (Check only one)

4 Homicide

1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

315

Year

ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad

ACHTCHININA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar 31. Date filed (Month, Day JUL 1 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, 893,000 gille alth and Mental Hygiene 1 - For State Registrar Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Warren **Physician** 65:12 AM 7 B Juli Carter ZECA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimeve-If Under 1 Year | If Under 24 Hrs. Hours | Min. University of Maryland Medical 5. Social Security Number 6. Sex 7. Age (1 Certer 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Days 1√2 M 2 □ F 44 03-06-1965 Wash., DC 217-98-3721 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evander must be notified at 1√Yes 2 No Director Hyattsville MD P.G. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20785 3112 Amador Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√√2 No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United Parcel College (1-4or 5+) Elementary/Secondary (0-12) driver Service alth and Mental Hv. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Harrington William Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ermit. Pages 1 and 2 st evartment of Health an mportant; If item 27 is r ny Injury or other traur 3112 Amador Drive, Hyattsville MD 20785 Florena E. Carter/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/13/09 Brentwood, MD Fort Lincoln 21. Signature of Funeral Service Libensee 22. Name and Address of Facility 420 H St.NE. B.K.Henry Funeral Home Wash., DC. Fart 1. In the disease, or complications that cause the dilath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a Pre-B cell ly me hobbestic leukenia with acute disease or condition resulting in death) /Medical complications Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) cate has been signed by the page 2 should be detached 9 Hinknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Pinours after death.

neral Director: After ty filled in by the funera 27. Manner of Death 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day Year) **JUL 1** 5 2009

Biskup

DHMH 17 Rev 1/2001

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Greene

29c. License number

Baltimore

1992964191

29d. Date signed (Month, Day, Year)

7/10/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** 8:30 P M July 8, Herman Carter, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Prince George Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 X M 2 □ F 59 July 4, 1950 North Carolina Director 242-84-7641 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Hyattsville Maryland Prince George the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20785 6612 Flagstaff Street United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 TXYes 2 □ No If Yes, Give Year or Dates: 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: African þ 3 Widowed 4 Divorced American Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Mechanic 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Lynch Herman Carter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) : If item 27 or other t Katrina Cooper/ Daughter 6811 Jade Court Capitol Heights, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Ju19 te 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department (Important: If any Injury or once. 16, 2009 4 Donation 5 ☐ Other (Specify) Clinton, Maryland Lee Crematory 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signeture of Fun ral Service License. W 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, for heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Factor **Physician** /Medical Due to (or as a consequend of): Examiner irrhosis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Sepsis Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X**1No 1 ☐ Yes 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ∐Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

Medical

and manner stated

who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

3001 Hospital De Cheverly MO 20785

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician July 7, 2009 Veronica Carpenter 7:38 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 10, 1946 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 63 216-48-8195 1 M 2 X F Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6482 Bock Road 20745 #306 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: Black δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samue1 Roland Flood Allen Mary Minnie ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tracy A. Carpenter / Daughter permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr. once. 6482 Bock Road #306 Oxon Hill, Maryland 20745 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/11/2009 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signatury of Funeral Service Licensee alas 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part . Enter the diseas or complications wat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROITC CARDIOVASCULAR DISEASE unknown Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner unknown LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the control of the cont Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and HYPERTENSION unknown attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical HYPOTHYROIDISM unknown IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 24X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) M⊠ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To the funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27, Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide Hospital 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

To the within 2

State Registrar

31. Date filed (Month, Day, JUL 1 4 2009

Arastoo Yazdani MD

29b. Signature and title of certifier



9135 Piscataway Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 50454

#235 Clinton, Maryland

29d. Date signed (Month, Day, Year)

July 07, 2009

		State Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death		3. Time of Death
Physic /Med		Carlton Allen Causey Sr.		July 10		2:00 рм
Exami	ner	4a. Facility Name (If not institution, give street and number) 32799 Johnson Road	4b. City, Town, or Location of Death Salisbury		4c. County of Death	
Funeral Director		220 00 07 10	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 08/15/19	Year) Co	nplace (State or Foreig untry) aryland
land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location			10d. Inside City Limits
a-f sh	ctor	Maryland Wicomico Sali	sbury			1 ☐ Yes 2 🔀 No
vith the	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
eath v	eral	32799 Johnson Road 11. Marital Status 12. Was Decedent Ever in U.S.	21804	necify Yes or No-	USA 14. Race - Ame	rican Indian
ges 1 and 2 should be lited within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Marical Examination must be notified at	Completed by Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 3 □ Widowed 4 🖔 Divorced Armed Forces? 1 🛣 Yes 2 □ No If Yes, Give Year or Dates: Army	13. Was Decedent of Hispanic Origin? (Sin 1998) If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White	
72 hc "natu	letec	15. Decedent's Education 16a (Specify only highest grade completed)	. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 1	6b. Kind of Business/	ndustry
within iene. than	omp	Elementary/Secondary (0-12) College (1-4or 5+)	painter		painting c	ontracting
z should be lifed w n and Mental Hygie is marked other ti raumatic event, Ita	To Be C	17. Father's Name (First, Middle, Last) Carlton Hildred Causey	18. Mother's Nam	ne (First, Middle, M Ne Tawes		
Health and Nealth and		Carolyn Causey/ex-wife	32799 Johnson Rd., S			ip Code)
permit. Pages 1.3 Department of He Important: If Item any injury or oth once.		20a. Method of Disposition 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Spring 4 🗆 Donation 5 🗀 Other (Specify)	f Disposition (Name of ry, crematory or other place) jhill Memory dens 7/14		Hebron, M	
Department of Important: If any injury or any injury or once.		21 Signature of Funeral Service Licensee CFSP	22. Name and Address of Facility Holloway Funeral 501 Snow Hill Rd.	Home Prof	fessional <i>l</i> urv, MD 218	Association 304
hysician /Medical		23a. Part 1. Enter the disease, or complication that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence	not enter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
xaminer	١	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ofj.			
filicate be executed by physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	of):			
cate by cate by the bu	Medical	d				
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	a 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
n signed build be deta	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.		acco use contribute to s 2 □ No 3 □ Pr	/
rife faw fequificate has been size has been size page 2 should	Completed			24a. Was an autopsy perform 1 □ Yes 2	prior to death?	topsy findings available completion of cause of
r this certificate ral director, page	Be C	25. Was case referred to medical examiner?		th (Check only one		
this or	2:	1 Yes 2 No		ome 5 Reside	nce 6 Other (Spe	cify)
the line	tion	1 Matural 5 Pending (Month, Day, Year) 2 Accident investigation	Time of 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe no	w injury occurred	
within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Str City or Town,	eet and Number or Ru , State)	ral Route Number,
e Funera	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination are and manner stated.				
W Comp	Me	29b. Signature and title of certifier	29c. License number		7113109	
St Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) RONAL PASSER 17.D. 3157 31. Date filed (Month, Pay Year) 4 2009 32. Higistrar's Signature		PKWY,	SAlis, 1	ND 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year Month JULY **Physician** 3:15 P M BETTY MARY JANE CRAMER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov. 27, 1923 Mary Year Moving 1923 Mary Tand 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔯 F 85 214-16-0322 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygbert. International them than "natural", or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, " Medical Event on the partition of the property of the page 1. 1 □Yes Ž∏ No Frederick Director Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 5546 Ballenger Creek Pike U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: ò 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) School School Food Service 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine R. Harrison William E. Oden ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5335 Pommel Drive, Mt. Airy, MD 21771 Larry A. Cramer, son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery July 24, 2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Record vocand Basford PA Funeral Home 21. Signature of Funerat Service Licens, e Richard 106 East Church St., Frederick, MD 21701 M00255 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Immediate Cause (Final Physician STROKE Dones disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit be exec Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month in the past 12 months? Year Day 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 124 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43091 7-22-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House Ave, Braderich MA Zaid 801 32. Registrar's Signature State Registrar

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		,					
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that initiated events resulting in death) Last	cDue to (or as a consec	quence of):					
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IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		☐ Ectopic pregnan	CV		23d. Date of deli	*
in the past 12 months? 1 ☐ Yes 2 No	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			Month	Day Year
9 ☐ Unknown Part II. Other significant conditions or		sulting in the I	inderlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
	•				24a. Was an	24b. Were au	topsy findings available
STATE PERMIT PALLACE	<i>-</i>				autopsy performe	d? prior to death?	completion of cause of
25. Was case referred to medical				26. Place of Death		_iNO 1 LiYes	Z LANINO
examiner? 1 ☐ Yes 2 ██No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatie	nt 3 DOA Oth			ce 6 □Other (Spe	cify)
27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wo		28d. Describe how	injury occurred	
2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		home form et			28f Location /Street	et and Number or Di	ural Route Number
4 Homicide determined	20e. Flace of Illiury - At I	cify)	ieet, iactory, onice		City or Town, S	State)	nai rioute Nuniber,
one)	niner: On the basis of examinand manner stated.	nation and/or i					
29b. Signature and title of certifie) ()						
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	Chronic Renal Failure 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	Chronic Renal Failure 25. Was case referred to medical examiner? Yes 2 No Hospital: I Inpatient 2	Chronic Renal Failure 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury 28c. Place of Injury - At home, farm, st building, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 25b. Was case referred to medical examiner: 28c. Place of Injury - At home, farm, st building, etc. (Specify) 28c. Place of Injury - At home, farm, st building, etc. (Specify) 29b. Signature and title of certifier	Chronic Renal Failure 25. Was case referred to medical examiner? 1 Yes 2 XNo	Chronic Renal Failure 25. Was case referred to medical examiner? Yes 2 No Hospital: I Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	Chronic Renal Failure 24a. Was an autopsy performe 25. Was case referred to medical examiner? The state of Death The state of Dea	Chronic Renal Failure 24a. Was an autopsy performed? Performed to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 1 Natural investigation investigation investigation investigation and place, and due to the cause(s) and manner as and manner stated. 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner of Death 1 Natural investigation investigation investigation investigation investigation and place, and due to the cause(s) and manner as and manner as and manner as and manner stated. 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier D24035 29c. License number D24035 24a. Was an autopsy performed? 2d how in provided death (Check only one) 24b. Were au autopsy performed? 2d how in provided death (Check only one) 26b. Place of Death (Check only one) 28c. Place of Injury at Work? 1 death or North (Month, Day, Year) 28c. Describe how injury occurred 28c. Location (Street and Number or Ruccity or Town, State) 29c. License number D24035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physicia /Medica Examine Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All (Copies Are Legible.
State of Maryland / Department of Health and Me	ntal Hygiene?
Certificate of Death	Reg. No.

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	3. Time of Dec 2030	ath M
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	for State Registrar			Ć	ertificate of	Death	F	Reg. No	- <u>-</u>	00	C. 4 U	
		e (First, Middle, Last))				2. Date of Dea			V	3. Time of D	eath
n		Lillia	n Jean Danie	els			Month July	1:		Year 2009	2030	M
al or	4a. Facility Name (/	f not institution, give			4b. City, Town, o	r Location of Death	1	40	. County	of Death		
	Car	roll Hospita	1 Center		We	stminster				Carro	011	
	5. Social Security N 235-54-3 Usual Residence of	6. Sex 1 E		e (In yrs. last birthd 81 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 11.	y, Year,) 28	Coun	lace (State or try) t Virgin	
	10a. State	10b. County		10c. City, Town o	r Location					10	d. Inside City	Limits
jo	Marryland	Carrol	1		Syste	esville					1 X Yes	2 □ No
rec	Maryland 10e. Street and Nur		1		10f. Zip Code	ESVIIIC		10g. Ci	itizen of \	What Coun	try?	
<u> </u>	720	O Third Aven	uo Ant C-	50		21784				U.S.A		
Jera	11. Marital Status		12. Was Decedent E		13. Was Decedent of h	lispanic Origin? (Sr	pecify Yes or No-		14. Rac	e - America		
To Be Completed by Funeral Director		ied 2⊠ Married 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ▼ N If Yes, Give Year or Dates:	√o	If Yes, sp <i>e</i> cify Cub 1 ☐ Yes 2 🗷 No	an, Mexican, Puerto Specify:	o Rican, etc.)		Blac Specify	ck, White, e	otc. Other	
ted		15. Decedent's Edu		16a. De	ecedent's Usual Occup	ation	(16b. h	Kind of B	usiness/Ind	lustry	
ple	Elementary/Seco	ordery (0-12)	completed) College (1-4or 5	\Ii	Give kind of work done fe. DO NOT use retire	during most of work d)	King					
Š	Liementary/3000	madry (0 12)	2	''	Hom	emaker				Own 1	Home	
စ္တ	17. Father's Name	(First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maide	n Surnan	ne)		
<u></u>		Cecil:	Hill			R	ath St Hel	lena	John	son		
•	19a. Informant's Na	ame/Relationship (Ty	pe. Print)		lailing Address (Street							
		e R. Daniels	- Husband		200 Third Av		C-59, Syke			Maryla: - City or To		
	20a. Method of Disp	position □ Cremation 3 🏿 F	Removal from State	cemetery,	isposition (Name of crematory or other pla	ce)	Date	200. L	ocation ·	- City or To	wn, State	
		5 ☐ Other (Specify)		Arlington	National Ce		3/06/2009	Ar1	ingto	n, Vir	ginia	
	21. Signature of Fu	meral Service License	ee		22. Name and Addre Hines-Rinal		Home. Inc.					
		MA			11800 New H	ampshire Av	enue, Silv	ver	Sprin	g, Mar	yland 20	904
	23a. Part 1. Enter t shock, or hea Immediate Cause disease or conditio resulting in death)	art failure. List only or (Final	ne cause on each lir	the death. Do not le.	enter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,			Approximate Interval Betw Onset and D	een
aminer	Sequentially list confidence if any, leading to imcause. Enter Under Cause (Disease or that initiated events	5 (Due to (or as a	a consequence of):								
Medical Examiner	resulting in death) i	Last	Due to (or as	a consequence of):								
Completed by Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 25 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ey				ate of delive onth	-	ear
든			ntribyting to death bu	ut not regulting in th	ne underlying cause giv	en in Part I.	23e. Did to	obacco	use con	tribute to th	e cause of de	ath?
d b		Lucy	Degentil	er Deul	uto		1 🗆 Y	es 2	2 □ No	3 ☐ Prob	ably 4 U	nknown
omplete			0				24a. Was a autop perfor 1 □Yes		/	prior to cor death?	psy findings a npletion of ca	vailable use of
Be	25. Was case refer	red to medical				26. Place of Dea						
	1 Yes 2	HVO H	lospital: 1 🖾 Inpatie	ent 2 ER/Outpa	atient 3 DOA Oth	er: 4 🗆 Nursing H	ome 5 Resid	dence	6 □Ot	ner (Specif	y)	
Medical Certification: To	27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	28a. Date of Inju (Month, Day	ry 28b. Tim y, Yea <i>r)</i> Inju	iry Woi	ry at k? Yes 2 □ No	28d. Describe h	now inju	iry occur	red		
Certific	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, farm c. <i>(Specify)</i>	, street, factory, office		28f. Location (S City or Tow			ber or Rura	i Route Numb	er,
edical	29a. Certifier (Check only one)			f examination and/	death occurred at the tor investigation, in my							
ž	29b. Signature and	title of certifier	wens		29c. Licen:			29d. D	ate signe	ed (Month, I	Day, Year)	
	30. Name and addi	ress of person who co	ompleted cause of d	eath (Item 23a) (Ty	rpe, Print) /()2 / / / / / / / / / / / / / / / / / / /	380 C S Cabone	y PS	5/	desi	buy L	4 217	fg

State Registrar

31. Date filed (Month, Day, Year)

JUL 14 2009

faces.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2009 **Physician** VIRGINIA ALICE DANIELS 20, ll:45A July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Allegany Memorial Hospital Cumberland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 💢 F 97 220-10-7007 Director 07/26/1911 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Eventimet must be notified at once. 10c. City, Town or Location 1 ☐ Yes 2 XNo Director Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11317 Silver Avenue, NE 21502 USA Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Cafeteria Manager Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Keplinger Reginald Blaine Hott Cora 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John B. Daniels / Son 11317 Silver Lane, NE, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 07/24/2009 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature Funeral Service Lipense 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician KESP DXYS disease or condition resulting in death) /Medical Due to (or as a conseq ence of): Examiner "IRATION Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in literal and the cause). Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trait resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 month 1 □Yes 2 □No Year Month 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 12 No 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: , filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) nes 500 State ž Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05320 State of Maryland / Department of Health and Mental Hygiene 828f. Willis Dempsey 1- For State Reg. No Registrar Amond#4b PorMFOPGC7
1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 6, 2009 1607 hrs Medical Examiner WILLIS DEMPSEY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Forestville Prince George's 2744 Lorring Drive #304 If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) g. Birthplace (State of 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months Davs Hours 01-26-1942 Director Country) 239-66-1756 1 X M 2 F 67 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Forestville tural", or items 23a or 28a-f show uniner must be notified at once. Maryland | Prince George's permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20747 USA 2744 Lorring Dr., Apartment 304 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funera 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 X Married Yes Specify: Black 1 Yes 2 X No specify: f Yes, Give Year 3 Widowed Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than her traumatic event, the Medical Baltimore, MD 21215-0036 Private Industry Transit Operator 4th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary M. Freeman Thomas W. Dempsey Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8600 Mike Shapiro Dr., Apt 716, Clinton, MD 20735 Vernice E. Dempsey/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 07-13-2009 Suitland, Maryland mportant Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Death Medical a. Intraoral Gunshot Wound Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlyin Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical the attending physician ed for use as the burial -UNPENDED AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death detached for use as 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed by Yes 2 ✔ No 3 Probably 4 Unknown ۾ Completed 24b. Were autopsy findings available 24a. Was an certificate has been prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Hospital: Residence 6 V Other: Scene ER/Outpatient 3 Nursing Home 5 Inpatient 2 this. 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject shot self Certification FOLIND: Yes 2 ✔ No Natural Pending within 24 hours after death.

To the Funeral Director: the Jul 6, 2009 1540 hrs 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Forest ville 2744 Lorring Drive #304, Suitland, MD 3 🗸 Suicide Could not be determined (Specify) Multi-Family Apt. Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifie O.C.M.E. July 7, 2009 Ko Name and address of person who completed cause of death (Item 23a)

State Registrar DHMH 17 Rev 1/2001

OCME 2006

111 Penn Street, Baltimore, MD 21201

Laron Locke MD.

Date filed (Month 2009)

Assistant Medical Examiner

Please Type or Print in Black Indelible lak3 Ensure All Gopies Are Legible. State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 21,00 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** $7:46 \text{ A}^{M}$ JAMES HENRY DUFFY JULY 112009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 119 PINE TREE ROAD WORCESTER OCEAN CITY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months 1**X** M 2□ F Days 036-18-8516 91 RHODE ISLAND **Director** APRIL 6, 1918 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Exantment be notified at 1X Yes 2 □ No Director MARYLAND WORCESTER OCEAN CITY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 119 PINE TREE ROAD 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY LAW 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PATRICK DUFFY GERTRUDE LEONARD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOAN L. DUFFY/WIFE 119 PINE TREE ROAD, OCEAN CITY, MARYLAND 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 7/13/09 4 ☐ Donation 5 ☐ Other (Specify) DELMAR, DELAWARE 21. Signature of Fur end Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multi System Organ disease or condition resulting in death) Due to (or as a consequence of): Diobetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Due to (or as a consequence of): Physician/Medical Colon CA IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner?

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

attending physician

Hospital or Attending Physician: The law requires that the death certificate be exect

after death Director:

24 hours a

within 2

P.O. Box 68760

Division of Vital Records,

Be Certification: To

D005870

26. Place of Death (Check only one)

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one) 29b. Signature and title of

3 Suicide

4 🗌 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

em

1001 Philadelphia Are, Ocem (ity m)

July 13, 2009

State Registrar

Medical

31. Date filed (Month, Day, Year) JUL 1 4 2009

ason

6 ☐ Could not be

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Mildred Ann Eckert 11:10 AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1 Meadow St. Apt 130 Berlin Worcester 8. Date of Birth 7/8/1919 (ear) If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) Days Hours Min. 90 Months 132-05-8789 NY Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 □Yes 2KINo MD Berlin Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1 Meadow St. Apt. 130 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2**X** If Yes, Give Year or Dates: 2**X** No 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: white 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward J. Kyle Henrietta Corrigan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Eckert / son 13031 Hayes Ave. #27, Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/14/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Crox 1 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling a Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a con figurence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use-contribute to the cause of death? 1 🗌 Yes Мо 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Cath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

/Medical **Examiner** P.O. Box 68760, Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

ð

Completed

Be

Examine

Physician/Medical

Completed

Be

Certification: To

Medical

4 Homicide

29a. Certifier

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene.
The 27 is marked other than "natural", or items 23a or 28a-f show the traumatic event, in Modical Economic must be notified at

permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau

Physician

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

determined

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed Month, Day, Year)

MUS 21862

and manner stated.

31. Date filed (Month, Day, Year)

JUL 1 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8, Marian Finch Ju1v 2009 6:40 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 26909 North Sandgates Road Mechanicsville St. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 1 □ M 2 🕅 F **Funeral** Months Days Hours Min 06/03/1925 **Director** 579**-**24-3465 84 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 X No Maryland St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 26909 North Sandgates Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: Completed by Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Man Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Matthew Windsor Annie Catherine Adele Farrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13695 Charles Street, Charlotte Hall, MD David W. Finch/Son 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛮 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery 107/13/2009 | Hollywood, Maryland St. permit. 21. Signature Frieral Service Licensee

Edward N. Brinsfield, Ir. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Candilo Physician A J disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to infine flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certification: To Be Completed Mella Vas 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1□Yes 2□No 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death. completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Manth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Youngsik Moon, M.D. 24435 Mervell Dean Rd., Hollywood, MD 20636 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 14 2009 Registrar

DHMH 17 Rev 1/2001

		1	For State Registrar	State o	f Marylan		artmen rtificat			and M		giene Reg. No:	009	24091
	Physicia	an	1. Decedent's Name (First, Middle, Betty Jane Franken)	•							2. Date of De Month	ath 11y 18, 2	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, Allegany County Nurs	give street and nu			4b. City,		Location o				County of Deat	h
	Funeral Director		5. Social Security Number 220-03-7558	6.Sex 1 □ M 2 1 F	7. Age (<i>In yrs.</i> 89	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da December	th 18, 1919	9. Birt Mar	hplace (State or Foreign Juntry) yland
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	Maryl -f sho	tor	Maryland Alleg	any	Mot	ınt Savag	ge							1 Yes 2 No
	or 28e	Director	10e. Street and Number 13211	Blank Road			10f. Zip					1.5	en of What Co	ountry?
	s 23e			12 Was Doo	edent Ever in U	C 13	2154		snanic Ori	nin? (Spe	ecify Yes or No	U.S.A.	4. Race - Ame	nican Indian,
· •	fter de	Funeral	11. Marital Status 1 Never Married 2 Marrie	Armed Fo	orces? 2 No		If Yes, spe	cify Cubar	n, Mexicar	i, Puerto	Rican, etc.)		Black, Whit	e, etc.
93	ours a	þ	3 Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve')ates:		1 Ves	/	Specify:				Specify: Whi	
21215-0036	n 72 h "natu edical	Completed	15. Decedent' (Specify only highes	t grade completed)		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	rk done d	luring mos	t of worki	ng	16b. Kin	d of Business	Andustry
212	d withii giene. r than	duo	Elementary/Secondary (0-12)	0 College (1-4or 5+)	homen	naker					home	maker	
land;	ild be filed lental Hyg ked othe iic event,	To Be C	17. Father's Name (First, Middle, I Pierce Albert Myers	.ast)					18. Mothe Eva O		(First, Middle	, Maiden S	Surname)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other treumeits event. I'm Medical Examinat must be notified at ance.		19a. Informant's Name/Relationsh Roger Frankenberry	nip (Type, Print) SON			ng Addres C alla Hi	•			it Savage		Town, State, . aryland	Zip Code) 21545-
altimore,	es 1 al of Hea of Hea of Hea r otha		20a. Method of Disposition 1 ★Burial 2 □ Cremation	3 Demoval from	1 ,	Place of Dispo cemetery, crea	osition (Na matory or o	me of other place	θ)		Date	20c. Loc	ation - City or	Town, State
Ē	ment tant: It jury o		`4 □ Donation 5 □ Other (Sp	ecify)	Res	lawn Mer				-	1, 2009	LaVale	· N	Maryland
Ball	permit Depart Impor any in		21. Signature of Funeral Service L	Wur	ef	1		uneral	Home	, 57 Fr			urg, MD	21532
	Physician		23a. Part. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition		caused the deal					cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death
*	/Medical Examiner		resulting in death)	Due to	(or as a consec	(uence of):	1							
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	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	unacca of):					·			
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9	ificate g phys as the	edic		0.		•	_							
.O. Box	ne death certificate be executed the attending physician and shed for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1											livery Day Year
Δ.	luires that the designed by the	by	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	underlying	cause give	en in Part	1.		Did tobacco use contribute to the cause of c		\mathcal{Q}
Vital Records,	The law requires ate has been sign page 2 should be	Completed									24a. Wa auto peri 1 Yes	s an opsy formad?	24b. Were a prior to death?	utopsy findings available completion of cause of
/ita		Be	25. Was case referred to medical examiner?	Hospitali				Oth	674		h (Check only			
of	Phys this ral di	lon; To	1 Yes 22 No 27. Manner of Death 1 Natural 5 Pendin	28a. Date (Mo.		ER/Outpatie 28b. Time o Injury	-	28c. Injun World	y at		me 5 Res 28d. Describe		S □Other (Spe y occurred	ecify)
Division	att att	Certification;	2 Accident investig 3 Suicide 6 Could a 4 Homicide determ	not be 28e. Plac	e of Injury - At I	nome, farm, st			103 2			(Street and own, State		lural Route Number,
_	Hospital 14 hours Funeral tely filled	edical Co	(Check only 2 Medicel one)	g Physician: To the Exeminer: On the and ma	basis of examin	ation and/or in	nvestigatio	n, in my o	pinion, de	ath occur	red at the time	, date and	place, and du	e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie	1			29	c. Licens	e number			29d. Dat	e signed (Mon	ith, Day, Year)
	511)	m				100	337	60		Vu	ly 18	,2009
	nas		30. Name and address of person-Suni K. Gu. 31. Date filed (Mozin Pay 2009)	pta, Ma	nse of death (Ite	m 23a) (Type Kenc	Frint)	e,, C	cun	ibe	rland,	m	0 219	502
ľ	St Regist	ate rar	31. Date filed (Mo2/10 2009	Deneur 32.	Registrat's Sign	akira Mes	/	(,			

DHMH 17 Rev 1/2001

Registrar

JUL 1 5 2009

09-05328

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ntnony Regina	1		ate of Death	Reg. No.	2003 2903
Physicia ledical Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Y July 7, 2009	ear 0150 hrs
iedicai Exami		ANTHONY REGINALD FORD 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dec	ath 4c. Count	ty of Death
		Prince George's Hospital	Cheverly		George's
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 X M 2 F 26		Vin. 12/14/1982	Foreign ASHTNGTON
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
A .11	5	DC WASHIN	IGTON		1 XYes 2 No
the Maryland a or 28a-f sho	Director	10e. Street and Number 314 54th ST., NE	10f. Zip Code 20019		D STATES
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygien Arman 22 or is marked other than "natural", or items 23a or 28a-f she armaire event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue Yes 2 X No specify: Decedent's Usual Occupation (Give kind)	erto Rican, etc.) W	ace - American Indian, Black, hite, etc. by: BLACK Business/Industry
36 thin 72 hour te. than "nate	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ${ m ABORER}$		ATE
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Con	17. Father's Name (First, Middle, Last) ANTHONY R. FORD SR.	ELLA	ame (First, Middle, Maiden Surna ${ m HASTINGS}$	
MD 21; nd 2 should be lith and Mer m 27 is mar	To	ELLA CAREY/MOTHER	b. Mailing Address (Street and Number $314\ 54$ th ST , NI	E WASH., DC 2	0019
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours Department of Health and Mental Hyggene Important: If frem 27 is marked other than "natuu important traumatic event, the Medical Exam		1 - Buriel 3 Cromotion 3 Removal from State cremat			OOVER, MD.
Balti permit. Departm Imports		21. Signiflure of Funeral Service Licersee	1425 MARYLAND	CAPITOL MORTU AVE., NE WAS	SH., DC 20002
Physician /Medical xaminer		23a. Part I. Enter the discass, or complications that caused the death. Doffailure. List only or excluse on each line. Immediate Cause (Final divease or condition resulting in death) Due to (or as a consequence of):	ot ề nter the mode of dying, such as cardi	ас or respiratory arrest, snock, or	heart Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
arted d ansit	Medical Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.			
e exect cian an rrial - tr	dical	UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after ceath. To the Funcral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	past 12 months?	Petal death 3 Ectopic pro		e of delivery th Day Year
P.O. B s that the d gned by the	þ	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.		ontribute to the cause of death? 3 Probably 4 Unknown
ecords, P.C. The law requires that the has been signed to ge 2 should be deta	_			24a. Was an autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medical	26.Place of Death (Ch	neck only one)	
FVIC Physici rthis c	To E	examiner? I ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/C	Outpatient 3 DOA Other, N Time of Injury 28c. Injury at Work?	lursing Home 5 Residence	1
ion of tending Pheath.		1 Natural 5 Pending FOUND: Day, Year) FO	UND: 1 Yes 2 ✔ No	Subject shot	333,134
Divisic pital or Afte ours after cea eral Directo	Certification:		12 hrs farm, street, factory, office building, etc.	28f. Location (Street and N or Town, State) 75 58th Street SE, Wash	umber or Rural Route Number, City nington DC,
Division To the Hospital or Attend within 24 hours after ceath To the Funeral Director: completely filled is by the	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, do one) Medical Examiner: On the basis of examination and/or	eath occurred at the time, date and place investigation, in my opinion, death occur	e, and due to the cause(s) and ma rred at the time, date and place, a	nner as stated. and due to the cause(s)
To To COU	Mec	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date July 7, 2	signed (Month, Day, Year) 2009
n 6		30. Name and address of person who completed cause of death (Item 23a)		MD 21201	
	tate			5, IVID 21201	OCME
Regis	Steen.		- -		VUNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Snell Fish Agnes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** COINSWA POSIONAL MEDICAL Social Security Number 6, Sex 7. A If Under Hours If Under 7. Age (In yrs. **Funeral** Months Days 1 □ M 2**X** F 68 Director Usual Residence of Decedent 10b. County 10c, City, Town or Location 10a State If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Worldal Examiner must be notified at Maryland Wicomico Mardela Spr Director 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. I have should be filed within the marked other than "natural", or items 23a or 2. and hijury or other traumatic event, the Medical Examination once.

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nder	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day, Year)		thplace (State or	Foreig
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				02,00,10			-
						10d. Inside City	Limit
-ir	ngs					1 □ Yes 2	2 XINe
	-5.0						_

Reg. No.

0

2009

4c. County of Death

10g. Citizen of What Country?

Salisbury, MD

USA

3. Time of Death

23:13 M

(State or Foreign

white

2. Date of Death

JULY

12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M∑No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12)

11699 Norris Twilley Road

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No Specify: Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry engineering 18. Mother's Name (First, Middle, Maiden Surname)

17. Father's Name (First, Middle, Last) Harold Snell

Funeral

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Be Completed

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760

11. Marital Status

Maxine Nelkin

19a. Informant's Name/Relationship (Type. Print) James Fish/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11699 Norris Twilley Rd., Mardela Springs, MD21837 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

7/13/09

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee

Salisbury Crematory Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Part / Enter the disease, or complications that cau is distributed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death

21837

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events

20a. Method of Disposition

umono. 49 Due to (or as a consequence of):

assistant

Due to (or as a consequence of):

Due to (or as a consequence of):

resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

Day

Year

25. Was case referred to medical 2 **N**o 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

2 🗆 No 2 **N**O 1 ☐ Yes 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 □ Could not be

28b. Time of 28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

4

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V15/40

HOOS9368

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Salishory MO

24 hours after death.
Funeral Director: After the etely filled in by the funeral

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State
Registra AMEND#5, perFH, 7/17/09, DPS, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 8,2009 **Physician** 11:00pm™ Allan W. Galfund /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Hebrew House 8. Date of Birth (Month, Day, Year) 8-20-1915 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Funeral 099-01-630915 Months Days Hours Min. 1 ₺ M 2 🗆 F 93 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20815 5500 Friendship Blvd. #2314 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Mayes 2 No
If Yes, Give 11-3-1950
Year or Dates: 7-31-1967 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, Ite Man Elementary/Secondary (0-12) College (1-4or 5+) US Army Lt. Colonel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Shine Max Galfund 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5500 Frienship Blvd #2314 N, Chevy Chase, MD 20815 Barbara Galfund/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) 9-25-09 Arlington, VA Arlington Nat Cem 22. Name and Address of Facility Joseph GAwler's Sons, INC 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL /Medical Due to (or as a consequence of): Examiner CORONDARY Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed Due to (or as a consequence of): burial-P.O. Box 68760, attending physician for use as the burial Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed: this certificate 20 No 2 No 1 □Yes i □Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Viursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MONTROS

29c. License number

6

D0061096

ROAD

29d. Date signed (Month, Day, Year)

20 85 2

07/09

ROCKVILLE MP

and manner stated.

6121

egistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOLLAPALY

State of Maryland / Department of Health and Mental Hygiene

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, it a Medical Examination in the inclined at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Stat Registra

	1 - State Registrar	Certif	ficate of Deat	th	Reg.	No. CUUJ	21000
ı	1. Decedent's Name (First, Middle, Last)				2. Date of Death	D	3. Time of Death
n	Alice Effie Gray				July 16,	Day Year	1:40 A M
ll .	4a. Facility Name (If not institution, give street and number)	41	o. City, Town, or Location	on of Death		4c. County of Deatl	
	26076 Three Notch Road		Mecha	nicsvi	11e	St. M	lary's
	5. Social Security Number 6. Sex 7. Age (In yrs. le		Under 1 Year If Un	der 24 Hrs.	8. Date of Birth (Month, Day, Ye	0 Riet	hplace (State or Foreign untry)
	217-60-6414 1□ M 2덫F 58	Yrs.	onths Days Hou		April 30,	1951 Ma	ryland
	Usual Residence of Decedent						
_	10a. State 10b. County 10c. City	, Town or Locati	on				10d. Inside City Limits
9	Maryland St. Mary's		Mechanics	ville			1 □ Yes 2 🙀 No
<u>e</u>	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?
<u></u>	26076 Three Notch Road		2065	59		USA	L
Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was	Decedent of Hispanic s, specify Cuban, Mex	Origin? (Specican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No		Yes 2 No Spec			Specify: Wh	
0	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					i	
Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give kind	t's Usual Occupation d of work done during r	nost of working	16b	. Kind of Business/	Industry
ᄅ	Elementary/Secondary (0-12) College (1-4or 5+)		NOT use retired)	J		01-71-1	0
	12	Day	Care Provid		(Eliza I Alaberta I A a l	Child	Care
Ř	17. Father's Name (First, Middle, Last)		18. M		(First, Middle, Maid	_	
0	Norman Herbert Hancock				Mary Erv		
	19a. Informant's Name/Relationship (Type. Print)		ddress (Street and Nu			-	
	Robert David Gray / Husband		Three Notch			csville,	
	20a. Method of Disposition 20b. Pl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ace of Disposition ametery, cremate	on (Name of ory or other place)	July	20.		
			rial Gardens	1	2009 Le	onardtown	, Maryland
	21. Signature of Funeral Service Licensee	- 1	ame and Address of Fa	,	moral Homo	D A	
-	Kenneth / hife	P	attingley-Gar .O. Box 270	Leonardt	town, MD 20	650	
	23a. Part 1. Enter the disease, or comp cations that caused the death shock, or heart failure. List only one cause on each line.	. Do not enter t	he mode of dying, such	n as cardiac or	r respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	RKNA	/ FAIL	100			Onset and Death
	disease or condition resulting in death) a. CIRALIC Due to (or as a consequence)	ence of):	,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Securetially list conditions b. DIANKTO	45					20 YEARS
<u>l</u> e	Sequentially list conditions, II any leading to immediate cause. Enter Underlying	enne of):					
Examiner	Cause (Disease or injury that initiated events c.						
	resulting in death) Last Due to (or as a consequ	ence of):					
Medical	d						
Mec	IF FEMALE:						1900
	23b. Was decedent pregnant		ctopic pregnancy			23d. Date of del	
sician/	in the past 12 months? 1 Yes 2 No 9 Unknown	eath 5 0	ther (specify)			Month	Day Year
y n	9 Li Unknown				00. 011.1	1.75	
	Part II. Other significant conditions contributing to death but not result	ilting in the unde	rlying cause given in Pi	art I.			the cause of death?
Completed by					1 ☐ Yes	2 No 3 Pr	robably 4 Unknown
be					24a. Was an autopsy	24b. Were au	stopsy findings available completion of cause of
Ď.					performed	l? death?	
Pe	25. Was case referred to medical		26. P	lace of Death	(Check only one)		
0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient	3 ☐ DOA Other: 4 ☐	Nursing Hom	ne 5 Aesidenc	e 6 ☐ Other (Spe	cify)
<u></u>	27. Manner of Death 1 Matural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	2	28d. Describe how i	njury occurred	
atic	2 Accident investigation		M 1 ☐ Yes 2	2 □No			
≝	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, street,	factory, office	2	8f. Location (Stree City or Town, S	t and Number or Ru tate)	ural Route Number,
Medical Certification:							
ca	29a. Certifier (Check only) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinar						
ledi	one) and manner stated.						
2	29b. Signature and title of certifier		29c. License numb			Date signed (Mont.	
1	Motor of 12 and 1 ms		D001	4168		July 17,	2009
	30. Name and address of person who completed cause of death (Item	23a) (Type, Prir					
	n 1 , r n	DT 37	L 1 7 4			1/0 000	F 0
	Robert J. Bauer, M.D. 28103 7		tch Road	Mecha	nicsville	, MD 206	59

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05433 State of Maryland / Department of Health and Mental Hygiene Hugo Arturo Gonzalez Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day July 11, 2009 Year 1448 hrs Medical Examiner Hugo Arturo Gonzalez 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) St. Mary's Lexington Park 21053 Three Notch Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Hours Months Davs Sept 9 1964 Director England 1_X M 2 F 218-96-0942 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State any 10b. County 1 Yes 2 XNo St. Leonard Calvert Maryland 23a or 28a-f show notified at once. hours after death with the Maryland rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States 20685 900 Morello Way Ö 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11 Marital Status or items 2 must be r If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married Yes Specify: white Yes, Give Year 1 Yes 2 X No specify: Widowed Divorced Pages 1 and 2 should be filed within 72 hours after hent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. 3 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Dept. of Defense Aero Space Engineer 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosita Flores Hugo L. Gonzalez Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 900 Morello Way St. Leonard, MD 20685 Cynthia E. Gonzalez - wife Baltimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition ulv 16 2009 crematory or other place) Alexandria Virginia Burial 2 xCremation 3 Removal from State Metropolitan Funeral Servide Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home PA 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death Madical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - transit sician/Medical AMENDED UNPENDED The las requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth attending detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a. Was an ficat has been a prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 1 🗸 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica Division of Vital Be Other 4 Hospital: 1 Residence 6 Other: Scene Nursing Home 5 ER/Outpatient 3 Inpatient this No ۵ 1 V Yes 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Bicyclist struck by vehicle Certification: Jul (Manth Day) 1445 hrs Yes 2 V No 1 Natural Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 21053 Three Notch Road, Lexington Park, MD Could not be 3 Suicide (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

State

31. Date filed (Month Cay, istrar's Signature Year) 5 2009

name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

and

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 12, 2009

Registrar

29

Signature and title of

Laron Locke MD

7/13/09 Amd Box 18 per FD crw Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2 per MD 2894 8/19/09 TT Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 111, **Physician** 2009 July 11:10pm [™] Milton Riggs Grimes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carrol1 3638 Schneider Lane Manchester If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Nov 23, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 ₩ 2 □ F Ĩ938 MD 213-38-1290 70 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3114 Bird View Road 21157 USA Funeral filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ∐Yes 2 📉 No Specify ò 3 ☐ Widowed 4 🛣 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, the Magnetic event College (1-4or 5+) Groundskeeper Maintenance 18. Mother's Name (First Middle, Maiden Surname)
Lillian B. Struby
-Lillian B. 17. Father's Name (First, Middle, Last) Be Edwin Warfield Grimes, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Miss Ginger Grimes (Daughter) 3638 Schneider Lane, Manchester, MD 21102 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🖫 Cremation 3 ☐ Removal from State All County Cremation 7/13/2009 |Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) HAIGHT FUNERAL HOME & CHAPEL, P MCOTG PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CELL CARCINGMA **Physician** ENAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Tue to for as a consecuence of: Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an cate has b page 2 sl autopsy performed? Yes 2 No certificate 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Be daughter Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Certifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 7/13/2009 3 30. Name and address of person who completed se of death (Item 23a) (Type, Print) West minster, MD 21158 Nagana, MD 700

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician July 10**,** 2009 6:15 P. M James Morgan Greene /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/16/1926 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 € M 2 🗆 F 82 FairmountHots.,Md Director 219-16-1027 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Capitol Heights Yes 2 □ No Md. P.G. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 20743 U.S.A. 5901 L Street within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XI Yes 2 Q No If Yes, Give 45— 46
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc.
African-1 ☐ Never Married 2X Married 1 □Yes 2 No Specify þ American 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Procurement Supervisor U.S. Government permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygid Important: If item 27 is marked other v any Injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Davis George Greene ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5901 L Street, Capitol Heights, Maryland 20743 Eunice M. Greene/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 07/21/09 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the r Isease, or complications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ igned Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death?

P.O. Box 68760,

Baltimore, Maryland 21215-0036

Division of Vital Records,

es

Physician: The law requir this certificate has been s al director, page 2 should I	01 0	www.	Vascular accord	1								
in it	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
nysic nis ce	direction of the second of the	1 Yes 2 No	Hospital: 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 [☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)								
ding Atter	e fune	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred 2 □No								
or A fter	n by th	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
To the Hospital or within 24 hours a To the Funeral C completely filled in	Medical (nysician: To the best of my knowledge, death occurred at the time, daniner: On the basis of examination and/or investigation, in my opinion and manner stated.									
To the vithin	a Me	29b. Signature and title of certifier	29c. License num	29d. Date signed (Month, Day, Year)								
,			completed cause of death (Item 23a) (Type, Print) M.D. 3001 Hospital Drive, Chever	rly,Maryland 20785								
Re	State gistrar	31. Date filed (Month, Day, Year) JUL 1 5 2009	32. Registrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Pedro July 6, 2009 3:35 P M Α. Guzman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Oct. 20, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex Year 944 **Funeral** Months 1 → M 2 ☐ F Dominican Republic 112-36-5158 64 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show 1 ☐Yes 2 No Director Prince George's 0xon Hill Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Dominican Republic 20745 580 Wilson Bridge Drive Apt. #B-1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Eventina once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1⊠Yes 2□No Specify Dominican Hispanic Specify: ò 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Enviromental Services Southern Maryland Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Guzman Dilia Estevez ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra E. Guzman / Daughter 3972 Martin Luther King Ave. S.E. #2 Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXXBurial 2 ☐ Cremation 3 ☐ Removal from State Md. Nat'l. Memorial Park 07/14/2009 4 □ Donation 5 □ Other (Specify) Laurel, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home P.A. of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. art 1. Enter the lisease, shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 1 Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contribution to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 2 🖾 No 1 ☐Yes 2 ☐No I∐Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X**XNo 1 □ Yes 1 🔲 Inpatient 25 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XXNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide FOR Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. d title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 4701 Randolph Rd. #216 Rockville, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oney Zuniga

te filed (Month Pays)

			1 - For State of Maryland /	Department of Health and Mental Hygiene Certificate of Death						
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year A Time of Death						
	/Medic	al .	HERBERT SANUEL	GILLAND SR. July 19, 2009 7:45 PM						
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death						
			Riverview Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last by	birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) Country Cou						
н	Funeral Director		218-03-9645 ¹ MM ^{2□} F 88	birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Yrs. Months Days Hours Min. 7/30/1920 9. Birthplace (State or Foreign Country) Maryland.						
			Usual Residence of Decedent							
	rylan show			own or Location 10d. Inside City Limits 1 ☐ Yes 2X No						
	Ba-1 s	cto	MD. Baltimore	MIGGIE KIVEL						
	vith th	Die	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country? 21220 United States						
	s 23g	erai	7325 Greenbank Road 11 Marital Status 12. Was Decedent Ever in U.S.							
	fter d	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, 2 ☐ No If Yes, Give Taffat T T	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.						
21215-0036	72 hours after death with the Maryland netural; or Hems 23a or 28a-f show iteal Evandrat must be notitled at		3X Widowed 4 □ Divorced If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 M No Specify: Specify: White						
5-0	72 ho	Completed by	15. Decedent's Education (Specify only highest grade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry						
21	within ene. then "	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	Carpenter Construction						
	filed with Hygiene. Ather ther	S	12 O	18. Mother's Name (First, Middle, Maiden Surmame)						
anc	d be f) Be	Herbert Samuel Gill							
Maryland	should I and Men Is marke	٦ ک		9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
	alth a		Samuel H. Gilland (Son) 1	3223 Rivervan Ave. Baltimore, MD. 21220						
J.	es 1 a of He of He fitem		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State	of Disposition (Name of Date 20c. Location - City or Town, State stery, crematory or other place)						
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evantmet must be notified at ance.		'4 □Donation 5 □Other (Specify) Bethe	el Cemetery 7/23/2009 Madonna, Maryland						
Balt			21. Signature of Funeral Service Licensee	22. Name and Address of Facility E.G. Kurtz & Son Funeral						
	Physician /Medical Examiner		200 Part State the disease of the death P	Home, P.A. Jarrettsville, Maryland						
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Immediate Cause (Final disease or condition)								
			disease or condition resulting in death) Due to (or as a consequence)							
В			(AT many	avery Disease we-know						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events .	ce of):						
	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events c.							
760,	be executed sician and burial-transit	i Ex	resulting in death) Last Due to (or as a consequence	:e ot):						
687	⊕ % ⊕	edicai	d							
Box 6	certifica nding ph use as th	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy							
	death a atter d for (iciar	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death							
P.0	The law requires that the death tte has been signed by the atter vage 2 should be detached for u	Physician/M	9 Unknown							
S,	w requires that been signed E should be deta		Part II. Other significant conditions contributing to death but not resulting							
ord	requir een s	ted	Choic about Johnille	24a. Was an 24b. Were autopsy findings available						
Vital Records,	The law ate has b page 2 si	Completed by	Choic and journe	24a. Was an autopsy performed? death?						
alF				1 Yes 2 No 1 Yes 2 No						
Σ:	Physicien: r this certificatel director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/	26. Place of Death (Check only one) Outpatient 3□ DOA Other: 4 ☑ Nursing Home 5 □ Residence 6 □ Other (Specify)						
of	g Phy er this eral c	⊢	27. Manner of Death 28a. Date of Injury 28t	b. Time of 28c. Injury at 28d. Describe how injury occurred liqury Work?						
ion	Attending or death. ector: After by the fune	atio	2 Accident investigation	M 1 Yes 2 No						
Division of	or Atter de Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	urs aft	Cel								
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical		dge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)						
			IN-V	0-38754 07-22-2009						
			30. Name and address of person who completed cause of death (Item 23: MALIKA WASESM. 70	D-38754 07-22-2009 (a) (Type, Print) (q. EASTERN BLVD., MD-21221.						
	Sta Regist		31. Date filed (Month Day, Year) 32. Redistrar's Signature	1 barles						
	ricgist	-GI	MOT # 1 5003 Vacange							

5th

			1 - For State Registrar	State of Ma	aryland		artmen rtificat			and M		giene Reg. No.	2009	24102
	Physici	an	1. Decedent's Name (First, Middle, La	ist)		_					2. Date of Dea Month	Day	Year	3. Time of Death
5	/Medic		James E. Hutson								July 0		009	5:17 P M
Jan	Examin	er	4a. Facility Name (If not institution, gir				,		Location of	of Death			County of Deat	
and the			Shady Grove Adve			ast birthday)	Roc If Under	kvil	le If Under	24 Hrs. T	8. Date of Birt		lontgom	thplace (State or Foreign
	Funeral Director			12 X M 2 □ F	52	Yrs.	Months	Days	Hours	Min.	(Month, Da)	v. Year)	Co	ryland
			Usual Residence of Decedent								02/10/	1931	IIa	Tyland
	yland Now		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	a-f s	ctor	MD Montgon	nery	Ge	ermant	own							1 □Yes 2 🙀 No
	or 28	Oire	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What Co	ountry?
	23a	Funeral Director	20709 Shakespear	e Drive				2087					ed Sta	tes
	r dea	nue	11. Marital Status	12. Was Decedent Armed Forces?		3. 13.	Was Deced	dent of H cify Cuba	ispanic Ori ın, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	- 1	 Race - Ame Black, White 	
36	or if	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣	No		1 □Yes 2	2X No	Specify:				Specify: W	hite
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show float Event for routh be notified at	pa pa	15. Decedent's E	Year or Dates:		16a Dece	dent's Usua	al Occun	ation		1	16h Kin	d of Business/	
5	in 72 "ra" r	Completed	(Specify only highest gr	ade completed)		(Give	kind of wor DO NOT us	rk done d se retired	during mos ()	t of worki	ng	100.1111	a or baoinooc	made i y
2121	with jiene	E	Elementary/Secondary (0-12)	College (1-4or 5	o+)	Tele	phone	Tec	hnic	ian		Tele	commun	ications Co.
p	other ent,	BeC	17. Father's Name (First, Middle, Las.	")			•				(First, Middle,			
a	ald be Aenta rked ric ev	P P	Robert Edward Hu	itson					Gei	nevie	eve Gro	ss		
Maryland	42 should be filed within 'th and Mental Hygiene. 7 is marked other than "traumatic event, Ith Ith	_	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address	(Street	and Numb	er or Rura	al Route Numbe	er, City or	Town, State, 2	Zip Code)
Σ,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wichail Event, or other traumatic event, the Wichail Event or other traumatic event or other tr		Marilyn P. Luke	(Wife)		2070	9 Sha	kesp	eare	Driv	e Germ			
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. PI c∈	ace of Dispo emetery, crer	sition (Nan natory or o	ne of ther plac	e)	July	7 10	20c. Loc	ation - City or	Town, State
Ĕ	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Speci		Met	ropoli	tan C	rema	itory	200		Alex	andria	, Virginia
salt	permit. Depart Import any Inj once.		21. Signature of Funeral Service Lice	TISEE M		22	2. Name an	nd Addres	ss of Facilit	by Del	ol Fun	eral	Home	
Ш	205 20		Marie 1	Nellet									rsburg	, MD. 20877
		5	23a. Part 1. Enter the disease, or con shock or heart failure. List only	plications that caused one cause on each li	d the death ne.	. Do not ent	er the mod	le of dyin	ıg, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
- Lange	Physician		Immediate Cause (Final disease or condition	_a Metasta	atic A	Adenoc	arcin	oma	on L	iver			!	Days
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):								
	Examine:	<u>.</u>	Sequentially list conditions,	b. Due to (or as	0.000000011	ones of):								
h	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter briderlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	ence oi).								
h	execu n and al-tra	Xar	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):								
8760,	The law requires that the death certificate be executed are has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	ical		- d										
89	ifficat g phy as the	edic												
Вох	h cert endin use a	M/n	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7 =					2	3d. Date of de	livery
W.	deatl e atte	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic p Other (sp		у				Month	Day Year
P.0	t the by th tache	hys	9 🗆 Unknown	9 □ Unknown										
s,	e law requires that the de has been signed by the le 2 should be detached	by P	Part II. Other significant conditions	contributing to death b	out not resu	Iting in the u	nderlying c	ause give	en in Part I					o the cause of death?
ord	equire sen si suld b	ted									1 🗆 '	Yes 2□]No 3∏P	robably 4 Unknown
Records,	law r as be 2 sh	ple									24a. Was autor		24b. Were au	utopsy findings available completion of cause of
- H	The ate h page	Completed									perfo 1 ☐ Yes	rmed?	death?	s 2 No
Vital	Physician: r this certifica ral director, p	Be (25. Was case referred to medical examiner?							of Death	(Check only o	ne)		
of	Physi this o		1 ☐ Yes 2 ☐XNo			ER/Outpatier			4 L IN		me 5 Resid			ecify)
ņ	ing F	in oi	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ary ay, Year)	28b. Time o Injury		8c. Injur Worl			28d. Describe I	how injury	occurred	
Sic	Attending r death. ector: After by the funer	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		At hou	en o former other	M		Yes 2		DOS Location (04 4	(Alembanas D	lund Davida Alumban
Division	or A after of Direction by	Certification: To	4 ☐ Homicide determined	28e. Place of In building, et	c. (Specify	ne, iarm, sir	eet, lactory	, once			City or To		i Number or H	ural Route Number,
	pital ours a eral filled	ŭ	29a. Certifier 1 X Certifying P	hysician: To the best	of my know	vledge deat	h occurred	at the tir	me date a	nd place	and due to the	cause(s)	and manner a	is stated
	To the Hospital or Attending Physician: The liviting 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page:	Medical		miner: On the basis of and manner st	of examinat	ion and/or in	vestigation	i, in my o	pinion, dea	ath occur	red at the time,	date and	place, and due	e to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of pertifier				290		e number			29d. Date	signed (Mont	th, Day, Year)
	1.7/		1 STT Yn	1 MI	7			121	551	50	2	J111	y 09,	2009
•	1		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	, ,	'				-, -,	
			WEI ZHAN	IG, MID				ente	er Dr	ive F	Rockvil	le, M	larylan	d 20850
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr		ure	-							
	Registr	ar	JUI 14 200	1 Buch	1	back								

DHMH 17 Rev 1/2001

			For State Registrar	State	of Mary	•	artment of H rtificate of		nd Mental Hy	/giene Reg. No. 2	009	24100
	Physici /Medi		Decedent's Name (First, Middle, Last Adelheid Rosemarie	·			_		2. Date of D. Month July 1.		Year	3. Time of Death 1:40 p M
1	Examir	4a. Facility Name (If not institution, given 13416 East Moser Road		umber)		4b. City, Town, o		Death		4c. County of Death Frederick		
ı.	Funeral Director		370 00 1307	ex □ M 2 XX F	7. Age (/ 86	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bi Min. (Month D Dec. 15	irth Pay, 1922	9. Birth Cou G en	place (State or Foreign ntry) nany
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	the Maryland r 28a-f show	al Director	Usual Residence of Decedent 10a. State 10b. County Maryland Frede 10e. Street and Number	erick	10	Oc. City, Town or Lo				10g. Citizen o		10d. Inside City Limits 1 ☐ Yes 2 🗷 No ntry?
	h with		13416 East Moser R	oad			21788			US	Ä	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventuals be notified.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dec Armed F 1 ∐Yes If Yes, G Year or I	orces? 21 No live		Was Decedent of H fYes, specify Cub 1 □Yes 2 12 No	dispanic Orig an, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. F B	lace - Ameri lack, White, cify: Wh i	etc.
	within 72 ho iene. than "natur re Madical I	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed) (Size kind of life. DO NO.) (Size kind of life. DO NO.)					of working		6b. Kind of Business/Industry Own. Home	
)d	al Hyg other	Be C	17. Father's Name (First, Middle, Last)			Ipolitaliance	-1-	18. Mother	's Name (First, Middle			
ylar	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma	To E	Hermann Juengst					Elisab	oeth Pappert			
-	P P E		19a. Informant's Name/Relationship (Michael A. Heller/			T .	-		or Aural Route Number Thurmont, M		vn, State, Zi	o Code)
imore	permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau		20a. Method of Disposition 1		State	20b. Place of Dispo cemetery, cren Gate of Hea	natory or other plac	ry (Date July 20, 2009	20c. Locatio	-	own, State Maryland
Ball	permit Depart Import any in		21. Signature of Funeral Service Licer	see	Day	Fr 50	Name and Addre ancis J. Co O Universi	ss of Facility ollins I ty Blvd.	Funeral Home W., Silver	Inc. Spring,	MD 2090	01
	Physician /Medical	202	Onset and Di									Approximate Interval Between Onset and Death 7 months
	icate be executed SX physician and U	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		onse wence of consequence of):						
P.O. Box 687	death certif e attending d for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 ☐ Live 4 ☐ Pre	If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown							ery Day Year
rds, r	es tha igned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute II. 25e. Did tobacco use contribute II. 27e. No 3 F.									
Ψ	The ate h	Completed	autopsy prio performs <u>d</u> ? dea							b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No	
7	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: ,	11		ot 3 🗆 DOA Oth	or:	of Death (Check only			
on or	Attending Physician: r death. ector: After this certific. by the funeral director, p	ion: To	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mo		2 ER/Outpatier 28b. Time of Injury	28c. Injui	y at		how injury occ		fy)
Division of	i Pire	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)							al Route Number,		
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in it	edical (stated. o the cause(s)	
	To the To the Comple	M	29b. Signature and title of certifier	Non	- ,	no	29c. Licens	e number d24543	3	29d. Date sig	ned (Month, fuly 13	-
			30. Name and address of person who				· ·	ver Spr	ing, MD 2090	5		
	Sta Registr		31. Date filed (Month, Day, Year) JUL 14 20		Registrar's		N.S.					
DHN	/H 17 Rev 1/2		LV	- Jun	and the same of the same	12. 19 an					 ,	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ne 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hebrew Home of Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 6 M2nth Pay 9 ear 2 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 463-16-2833 97 Texas Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examinar must be rediffed at Md Montgomery Rockville 1XYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 6121 20852 Montrose Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2X No Specify: Black Specify ⋧ 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any Injury or other traumatic event, the Media once. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Cosmotologist Cosmotology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur McDaniel Leola Seals ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marcia J.Clinkscales/Daug. P.O.Box 10312 Silver Spring, Maryland 20914 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Chesapeake Crem. 7/13/2009 5 ☐ Other (Specify) Beltsville, Md 4 Donation 21. Signatur of Funeral Service Lic PHILIP ADERINALDI FUNERAL SERVICE, P.A 9241 Columbia BLvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. COBSTRUCTIVE PULMONARY DISGASS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): STIVE HEMET FAILURG **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 M No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 DNo certificate 2 **D**No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 12 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Winner of Death 1 V Natural completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records,

Saltimore, Maryland 21215-0036

Box 68760,

P.0.

State Registrar

Medical

31. Date filed (Mönth, Day, Year) 14

29b. Signature and title of certifie

29a. Certifier

(Check only one)

121 MONTROSERD, ROCKVILLE, MD 20852

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death
7:47 A 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Charles Floyd Hall, Jr. /Medical Town, or Location of Death y of Death Eacility Name (If not institution, give street and number) Examiner ARLE Plata 9. Birthplace (State or Foreign Country)
30,1957 Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Days Months 1 ☑ M 2 □ F 52 217-74-5573 Director January Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 10a, State 10b. County or items 23a or 28a-f show Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment must be notified at 1 ☐ Yes 2 No Director Brandywine Charles Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20613 15960 Covington Rd. 14. Race - American Indian, Black, White, etc. White Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Heavy Equipment Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Alvey Charles F. Hall, Sr. Injury or other traumatic ျှ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Hall/Son Department of Health a Important; if item 27 is any Injury or other trains Brandywine, MD 20613 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery Date 20a. Method of Disposition Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 18, Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brins 1e1d-Echols F.H., 21. Signature of Funeral Service Licensee M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one care on each line. Approximate Interval Betwee Onset and Dea immediate Cause (Final disease or condition resulting in death) **Physician** AKC ane My C /Medical ue to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE use ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the 29d. Date signed (Month) Day, Year) 29b. Signature and title of certifier 29c. License number 0 dress of person, who completed cause of death (Item 23a) (Type, Print) Suite 103 Waldorf, MD MD George H. WATHEN 11345 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Wilson T. Holland July 8, 2009 2:38 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1795 Stinnett Road Calvert Huntingtown
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**⊠**M 2□ F Yrs. **Director** MD 214-18-8655 December 15, 1911 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shorthe Modical Exercises to notified at 1 ☐Yes 2KNo Director Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1795 Stinnett Road 20639 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: "natural", or it 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. 3≅ Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction <u>Foreman</u> marked other artment of Health and Mental Hyg ortant: If item 27 Is marked other injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit, Pages 1 and 2 should be file Department of Health and Mental He Important: If item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last, James Holland <u>illy Green</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Plater - niece P.O. Box 1849, Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 16, 2009 Huntingtown, MD Holland Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sewell Funeral Home, P.A. Isladys a Servel 1451 Dares Beach Rd., Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARCINOMA OF **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of) physician a the burial-t Box 68760. Physician/Medical attending ph IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month 5 Other (specify) signed by the a be detached f Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ MENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 s autopsy page performed death? After this certificate I 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No Hospital or Attending Physiclan: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Fresidence 6 Other (Specify) 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 ☑ Natural 28b. Time of funeral 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JRW &

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day,

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32. Registrar's Signature

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14 2009

FREDERICK, MID-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 8:45 p July 8, 2009 Selma B. Hawkins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heart Homes Assisted Living Odenton Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 K F Months Days Hours Min. October 6, 1931 Director MD 577-48-0228 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hours after death with items 23a 20639 USA 1900 Kings Landing Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 KNo þ Specify. 3XWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2 should be filed withii h and Mental Hygiene. Someone Else's Home Domestic is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Henrietta Brown Jacob Coby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Alphonso W. Hawkins - son 1900 Kings Landing Road, Huntingtown, MD 20639 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of F
Important: If iten
any injury or ott
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Southern Mem. Gardens: July 15, 2009 Dunkirk, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sewell Funeral Home, P.A. ewel 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** هے تین /Medical Examiner Sequentially list conditions Examiner riany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed th ma physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 Other (specify) P.0. signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page this certificate 1 □ Yes 2 140 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 1 ∐ Yes 2 🖼 🕷 1 Inpatient 2 ER/Outpatient 3 DOA 6 Sother (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral 28b. Time of 28d. Describe how injury occurred 27 Manner **at**Death 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Funeral Director: npletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after 4 Thomicide Hospital 29a, Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (nem 23a) (Type, Print)

State Registrar (01)

31. Date filed (Month, Day,

MO

32. Registrar Signature

		,	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artme: <i>rtifica</i>			Mental F	lygiene Reg. No	000	C	24108
Ш	Dhyoisi		1. Decedent's Name (First, Middle, La				2. Date of Month	ate of Death fonth Day Year 3. Time of Dea					
¥	Physici /Medic		John Behr Hession, M.I			July		13 2	2009	9:00 p ^M			
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)	,		Location of Dea	ith	40	. County of [Death		
			84 Harkins Lane 5. Social Security Number 6. S	7 4-	a (In use loot hirthday)		esapeak er 1 Year	ce City If Under 24 Hr	s. 8. Date of	Dirth	Cecil 9. Birthplace (State or Fo		
Ш	Funeral Director			M 2 F 8	e (In yrs. last birthday) Yrs.	Months		Hours Mir	n. (Month,	Day, Year,		Country	NY
			Usual Residence of Decedent	01		<u> </u>			Januar	y 26, 192	.3		141
	yland now at		10a. State 10b. County		10c. City, Town or Le	ocation						10d	. Inside City Limits
	a-f sh	ctor	MD Chesapeal	ce City	Cecil								1 ☐ Yes 2 ☐ No
	or 28 e not)ire	10e. Street and Number			10f. Z	ip Code			10g. Ci	tizen of Wha	t Country	?
	23a ust b	ra	84 Harkins Lane				915			US			
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show wit, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		Was Dec If Yes, sp	ecify Cuba	ispanic Origin? (an, Mexican, Pue	Specify Yes or erto Rican, etc.)	No-	14. Race - A Black, N	Amencan White, etc	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 ☐ f If Yes, Give Year or Dates:		1 ☐ Yes	2 No	Specify:			Specify:	Whit	A
0	hour Itural	ed	15. Decedent's E		16a, Dece	dent's Us	ual Occup	ation		16b. K	ind of Busin		
75	nin 72 n "na Medic	Bet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	(Give	kind of w DO NOT	ork done d use retired	during most of w l)	orking	10			
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Maryland 21215-0036	should be fand Mental I s marked or umatic eve	2	Henry F. Hession						ia A. Behi				
lar	2 sho		19a. Informant's Name/Relationship (Турө. Print)			,	and Number or I				ate, Zip C	rode)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Maeve O. Hession/Dau	ghter	20b. Place of Disp			Chesapeak	City, MD			T	01-1-
Baltimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or	other plac	ce)	Date	200. L	c. Location - City or Town, State		
Ē	permit. Page Department (Important: If any Injury or once,		4 □ Donation 5 □ Other (Special		Bethel Cen		and Address	ss of Facility	y 16, 2009		Chesape	ake Ci	ity, MD
Bal	Depar Impor any Ir		21. Sign sure of Full Service Lice	nsee				,					
			23a. Part1. Enter the disease, or com	inflications that caused				e Funeral I			n St., El		MD 21921 Approximate Interval Between
			shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.		100	010	- 40			li C	nterval Between Onset and Death
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90,	e exe	Ä	resulting in death) Last	Due to (or as	a consequence of):								
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Division or Vital Records, P.O. Box	that the death cerlifi ed by the attending I detached for use as	cian	in the past 12 months?	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy							Month	,	ay Year
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σ.	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	무	Part ii. Other significant conditions	contributing to death b	ut not resulting in the I	underlying	cause giv	en in Part I.	23e. D	id tobacco	use contribu	ite to the	cause of death?
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Ä	The lay te has age 2	шо								utopsy erformed? es 214 N	dea	th?	oletion of cause of No
<u>ta</u>		Be C	25. Was case referred to medical					26. Place of D	eath (Check or				Ano
>	Physici this cer at direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatie	nt 3 🗆 🗆	OA Oth	er: 4 Nursing	Home 5 🗆	esidence	6 □Other	(Specify)	
0	ng Ph ter th neral	l:n	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		of	28c. Injur Wor	y at k?	28d. Descri	be how inju	ry occurred		
0	Attending Physician: r death. ector: After this certific: by the funeral director, I	Certification:	2 ☐ Accident investigation			М		Yes 2 ☐ No					
Ž	or Att ter de lirect	Ħ	3 ☐ Suicide 6 ☐ Could not be determined	Zoe. Place of Inj	ury - At home, farm, si c. <i>(Specify)</i>	treet, facto	ory, office			n (Street a Town, Stai		or Rural I	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral												
	Hosp 24 hou Fune tely fi	Medical		hysician: To the best miner: On the basis o and manner st	f examination and/or i								
	thin 2 the orthe	Med	29b. Signature and title of certifier	and marrier st	ateu.	2	9c. Licens	e number		29d. D	ate signed (/	Month, D.	ay, Year)
	ĕ∓ĕŏ		I An cee	iclo 1	11)		Dina	823			14/00	_	
,			30. Name and address of person who			, Print)					•	•	
0	4 IVA			HSUMD	223	Nes	43	mari s	t Elk	ton	M-	12	1921
3	Sta	ate	31. Date filed (Month, Day, Year)		ar's Signature								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William July Joseph Hancock 12 2009 1:52 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Aug 18, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ^{Year)} 1963 1 ₩ 2 □ F Months Days Hours Min. Aug 214822803 45 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No MD P.G Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20735 8509 Kebbler Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 21√2 No Specify: Specify: White 3 ☐ Widowed 4 🏌 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sausage Plant/Food 12 <u>Manager</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald H. Hancock Ruby Ice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9901 SW 62rd Ave, Ocala, Florida 34476 Lee R. Ice (Uncle) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 7-16-2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, Md 20735 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) MPY4 TNSKY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) Manner of Death

1 Natural

2 Accident 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical **Examiner** Examiner that the death certificate be executed burial-tran P.O. Box 68760, Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

Is marked other than "natur raumatic event, the Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic event, once.

filed within 72 hours after death with the

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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the attending p for use as t

After this certific funeral director, or Attending ours after death.
neral Director: A
filled in by the fu To the Hospital within 24 hours a To the Funeral I Hospital

Be Completed by

Medical Certification: To

29a. Certifier (Check only one)

Division of Vital Records,

State Registrar

DU01923

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

13/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Fieldson, 2068 Crain Hwy, Waldorf,

31. Date filed (Month, Day, Year) JUL 1 4 2009

29b. Signature and title of certifier

32. Registrar's Signature

			Please Type or Print in Black In State of Maryland / Dep 1 - For State Registrar Ce		Mental Hygi	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) ALAN EDWARD HARTMANN	The superior of Double		13 ^{Pay} 2009 5:00 PM M
16	Examin	er	4a. Facility Name (If not institution, give street and number) 420 THE POND WAY	4b. City, Town, or Location of Death CHURCH HILL		4c. County of Death QUEEN ANNE
	Funeral Director		5. Social Security Number 282-44-6501	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, FEB. 11,	9. Birthplace (State or Foreign Country) 1947 DELAWARE
	e Maryland 8a-f show	ector	Usual Residence of Decedent	HILL		10d. Inside City Limits 1 ∐Yes 2 X No
	with th	I Dire	10e. Street and Number 420 THE POND WAY	10f. Zip Code 21623	10	og. Citizen of What Country? USA
9600	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It. "Clost Exam in the north of a state of the control	d by Funeral Director		Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
21215-0036	within 72 ho ene. than "natu Modool	Completed	(Specify only highest grade completed) (Given life.) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) LES	king	16b. Kind of Business/Industry AUTOMOTIVE
Maryland 2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In. M. once.	To Be Co	17. Father's Name (First, Middle, Last) EDWARD WILLIAM HARTMANN		e (First, Middle, M	
Mary	12 short h and h 7 is ma trauma		, , , , , ,	ing Address (Street and Number or Ru		
Baltimore, I	Pages 1 and ent of Healt nt: If item 2: y or other		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 20b. Place of Disposition CHESAPEA	THE POND WAY, CHUI osition (Name of KEONCREMATION JULY ENTER 20	Date 2	20c. Location - City or Town, State STEVENSVILLE, MD
Baltii	permit. F Departm Importar any injur	FUNERAL HOME, P.A.				
60,	Physician //Medical Examiner e pe executed for property of the	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to him solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	eter the mode of dying, such as cardiac	or respiratory arre	est, Approximate Interval Between Onset and Death
O. Box 687	ath certifical attending phy or use as th	Physician/Medic		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	quires that the de in signed by the a uld be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the INGUCTN DEPENDENTI	underlying cause given in Part I.		oacco use contribute to the cause of death? s 2 ☐ No 3 ♣ Probably 4 ☐ Unknown
Records,	The law requir ate has been s age 2 should	Completed	CORDNARY ARTER	Y DIZENSE	24a. Was ar autops perforn 1 \(\text{Yes} \) 2	y prior to completion of cause of
Vital	hysician; The la his certificate ha I director, page 2	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Dea	th (Check only one	
of	ffe ffe	tion: To	1	ent 3 DOA 4 Nursing H		ence 6 □Other (Specify) w injury occurred
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St. City or Town	reet and Number or Rural Route Number, n, State)
	the Hospi in 24 hour the Funera pletely fill	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occu	irred at the time, d	ate and place, and due to the cause(s)
	To t To t	Z	29b. Signature and title of certifier 2 max (29c. License number > 35048	2	9d. Date signed (Month, Day, Year) 7 (4) 5
			30. Name and address of person with control of death (Item 23a) Type ERIC F. CIGANEK, M.D. 629 RAILROAL	, Print) AVENUE, CENTREVI	LLE, MD 2	21617
	Sta Registr		31. Date filed (Month, Day, Year) JUL 15 2009 32. Registrar's Signature			

amend #18 Per TH G894. 8/04/09 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** July 7, 2009 5:00 P M Joyce Antinette Hopkins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Aug.) | 9, Prince George's Pineview Nursing Home 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** North Carolina Months 1 □ M 2 🖺 F 1927 577-40-2803 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Temple Hills Maryland Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 USA 4015 Danville Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any Injury or other traumatic event, Its Medical Examina 1XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense Personnel Clerk 18. Mother's Name (First, Middle, Maiden Surname)

19. Morsley 17. Father's Name (First, Middle, Last) Be 2 Earnest Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship '(Type. Print) 4015 Danville Dr., Temple Hills, MD 20748 Louise H. Dunlap - Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cemt 7/14/2009 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Fund Service Deense 22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, the entert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician The law requires that the death certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy for Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown the detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🕅 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day, Year) 28b. Time of after death. 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D50545 7/8/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Godswill Okoji, M.D. 7513 New Hampshire Ave., Takoma Park, MD 20912 31. Date filed (Month, Day, Yea

JUL 1 4 2009 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Ann Iames 18 Jeane 2009 11:20 A July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Golden Living Center Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/20/1933 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 75 Months Hours Min. 1 □ M 2 🕅 F Yrs. Director 220-28-9500 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Directo MD Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with than "natural", or items 23a or 15516 Baltimore Pike, N.E. 21502 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r any injury or other traumatic event, the May once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Edward baker Mary Catherine ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alton L. Iames / Husband 15516 Baltimore Pike, NE, Cumberland, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Prosperity Christian Cem. 07/21/2009 Hewitt, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hzaid Immediate Cause (Final bro vasular months **Physician** ere disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No 1 ☐Yes 2 ☐No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 \(\) Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2009 10033220 8

MAS

Registrar

625 Kent Avenue, Cumberland,

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil Gupta,

20 2009

31. Date filed (Month, Day, Year)

M.D.,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Ju₁y 10. 2009 4:40a Patricia Jameson Marv /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles 13038 Aubrey Jameson, Sr. Place Waldorf | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March | 10,1936 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mary Land 1 □ M 2 □XF 220-32-6267 73 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Items 23 or 28a-f show tem 27 is marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Evanting in ust be notified at 1 ☐Yes 2 No Maryland Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20601 USA 13038 Aubrey Jameson Sr. Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Accounting Clerk SMECO 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James C. Jameson ဂ Mary C. Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6620 Boone Place, Hughesville, MD 20637 19a. Informant's Name/Relationship (Type. Print) Pages 1 ar nent of Heal nt: If item 27 Bonnie Johnston/Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Parial 2 Cremation 3 Removal from State permit. Page:
Department o
Important: If
any injury or St. Mary's Cemetery July 15,2009 Bryantown, MD 4 Donation 5 Dother (Specify) 21. Si matura of Fune al Ser ice Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): ABBOMINE AND Viscual Metosposes Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed taluo Carcenomo burial-trar Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) ı∐Yes detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. φ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐Yes 2 No 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 Nursing Home | 5 \(\text{X} \) Residence | 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 1 24 hours after death, le Funeral Director: A bletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely

within 24

Maryland 21215-0036

Baltimore,

P.O. Box 68760.

Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

John W. Roache, M.D. 28130 Three Notch Rd., Mechanicsville, MD 20659 22. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 a **Physician** 6:00 P M July 10 Elizabeth Jones Helen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Dunkirk 1414 Knight Avenue If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth (Month, Day, Year) 09/17/1944 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Months 223-60-9227 64 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Widdal Event or other traumatic event, the Widgal Event or other traumatic event or other trau 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No **Funeral Director** Dunkirk MD Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20754 1414 Knight Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white Specify <u>م</u> 3 X Widowed 4 □ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Cashier Supervisor Finance, Lending 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cox Helen Elizabeth Schumacher Holland Joseph ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1609 Cedar Road, St. Leonard, MD 20685 Robert W. Jones, son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Harmony Cemetery 07-15-2009 Owings, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WETERDIN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 mont 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ NO been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 ∏ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 sl autopsy performed 2 🗆 No 2 D 1 ☐ Yes a er death. I Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 2 No 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours a e Funeral Di letely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signat

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State Registrar Na

31. Date filed (Month, Day, Year) 32. Registrar's Signatu

JUL 14 2009 Denus S. San

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** July John Elwood Jacobs 06 2009 11:10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner George's Prince Georges Hospital Center Cheverly Prince 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 26 Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 12XM 2□ F Yrs 90 1918 Dec NC Director <u>578-12-9066</u> Usual Residence of Deceden 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examinar must be rigiting at 1 XYes 2 No MD Prince George's Capitol Heights Director 10g. Citizen of What Country? 10e. Street and Number 1619 Quarter Avenue 20743 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Private 3rd other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental Intern 27 is marked of Junious Jacobs Lillie Jones P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1619 Quarter Ave Capitol Heights MD 20743 Linda Jenkins - Niece July 11 20b. Place of Disposition (Name of cometery, crematory or other p 20c. Location - City or Town, Stete 20a. Method of Disposition cometery, cromatory or other place)
Riverdale Park Cre 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD permit. Page Department of Important: If any injury or 2009*** 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DLMcLaughlin Funeral Home 2019 MLK Jr Ave SE Washington DC 23a. Part1. Inter the disease, or com-lications that shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Sepsis resulting in death) /Medical Due to (or as a consequence of) **Examiner** Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit Choangitis Due to (or as a consequence of): the attending physician Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ peq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed The page 2 🗆 No certificate 1 Yes 1 Tes 2 No Attending Physician: 25. Was case referred to medical funeral director 26. Place of Death (Check only one Be Hospital: 1 █ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death 2 ☐ Accident investigation the Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide after ō within 24 hours a Hospitel 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) MD Juspeen idalgun 00067810 0

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) JUL 1 5 2009

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

AMBREN S. SIDDIQUE.MD 3001 Hospital Dr., Cheverly MD 20785 32. Registrer's Sign

			For State Registrar	State o	f Marylan	-	artment rtificate			and M	lental Hy	giene Reg. No	000	Q	24	116
			1. Decedent's Name (First, Mid	dle, Last)							2. Date of De	eath Da	v V	ear	3. Time of	Death
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N. S. S. S.	Examir	ner	4a. Facility Name (If not institut		-	t.803	4b. City, T			of Death			. County of			
			Somerset Ho 5. Social Security Number	use 5610 W	1SCONS1 7. Age (In yrs.		Chevy		ase If Under	24 Hrs.	8 Date of Bir	- 1	Montg		y ce (State o	or Foreign
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	5)		30. Name and address of person	on who completed cau	se of death (liter	11 23a) (Type.	Print)									
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			1 - For State Registrar		State of M	aryland		rtment of F tificate of	tealth and I Death		Glene Reg. No.	009	24117
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,	/Medic			YN RUTH F						07	11	2009	
	Examin	er	4a. Facility Name (/:	t not institution, give LIVING CE)		CUMBER	r Location of Death	ı		ounty of Death LEGANY	
	Funeral		5. Social Security N	umber 6. S	ex 7. Ag	ge (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth	9. Birth	place (State or Foreign
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	and Sw		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
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	er deg	Funeral	11. Marital Status		12. Was Decedent Armed Forces	?	13. V	Vas Decedent of F Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.))- 14	 Race - Amer Black, White, 	ican Indian, etc.
20	filed within 72 hours after death with the Maryland Hygion. ther than "natural" or items 23a or 28a-f show int, The Pacifical Evanding to polithed a	by	3 V Widowed	ied 2 ☐ Married 4 ☐ Divorced	1 ∐Yes 2▼ If Yes, Give Year or Dates:	140	1	□Yes A∏No	Specify:		S	pecify: WHI	TE
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AISIOD AISIOD	Attendent death	fical	2 ☐ Accident 3 ☐ Suicide	6 Could not be determined	28e. Place of Ir			eet, factory, office				Number or Ru	ral Route Number,
5	al or safter	Certification:	4 Homicide	dotominod	building, e	etc." (Specify)				City or To	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after the death. within 24 hours after the death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (29a. Certifier (Check only		ysician: To the bes niner: On the basis	of examination							
	thin 2 the l	Med	one) 29b. Signature and	title of certifier	and mainner s	stated.		29c. Licen:	se number		29d. Date	signed (Month	n, Day, Year)
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	Sta Registr		31. Date filed (Mon	th, Day, Year) 2009	General Services	trar's Signatu	park	'al					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No._ 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** Delores Lorraine KLINE JU 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fahrney-Keedy Nursing Home Boonsboro Washington Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 12, 1 5. Social Security Number 7. Age (In vrs. last birthday, Funeral Hours Days 73 Maryland 220-30-9459 1935 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, fro Modical Examinar must be realised at 1 ☐Yes 2 X No Director Maryland Washington Boonsboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21240 San Mar Road 21713 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify þ Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education cafeteria worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes L. Younkins Russell L. Moser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Kline - son 21211 San Mar Road, Boonsboro, Maryland 21713 permit. Pages 1 and Department of Healt Important: If item 2: any injury or other i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/20/09 Myersville, Maryland Grossnickle Ch.Cem. 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 5M disease or condition resulting in death) /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. been signed by the a should be detached t 1 ☐ Yes 2 XNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \) No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Shursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

To the within 2 State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Khalid Waseem, 1126 Opal Court, Hagerstown, Md. 32. Registrar's Signature

Registrar

29c. License number

29d. Date signed (Month. Dav. Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month ^{Day} 2009 **Physician** Ju₁y 12 10:45 Ellen Kindred Margaret /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 24, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Year Months Days Hours 1 □ M 2X F Illinois 331-14-4295 1920 88 Oct. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Frederick Middletown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21769 U.S.A. 4497 Tulip Tree Lane Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. \$ 3 ☐ Widowed 4 A Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home les 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie ff item 27 is marked other to other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 01a Fae Atteberry William Silas Warrick ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4497 Tulip Tree Lane Middletown, Maryland 21769 Vicki Campbell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H.
Important: If iter
any injury or ott 1 Burial 2 XCremation 3 Removal from State 7/17/2009 | Frederick, Maryland 4 □ Donation 5 □ Other (Specify) Stauffer Crematory 21. Signature of Funeral Service License Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dey S Physician Complications of Hip Fracture disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year signed by the atte in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ☐Yes 2XNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1MYes 2□ No 2 ER/Outpatient 3 DOA မ 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 No July 7, 2009 5 Stood from table and fell 2X Accident Director: / 28f. Location (Street and Number or Rural Route Number, 19800" Trainguility Circle Hagerstown, MD 21742 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital or Attending Physician:

31. Date filed (Month, State Registrar

Medical

29a. Certifier

one)

29b. Signature and title of certifier

Sanjay Saxena, MD



Nursing Home

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

166

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D-0056413

29d. Date signed (Month, Day, Year)

7/14/2009

21740

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		For State Registrar	Sic	ale or ivid	ai yiai k	-	tificate of		vicillai i i	Reg. No.		24/20
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/Medic Examin	al	4a. Facility Name (If not institution					4b. City, Town, o	r Location of Deatl	July	/ 8 4c.	County of Death	1540 M
LXaiiiii			Region		dica	1 Cente	If Under 1 Year	alist If Under 24 Hrs.	YYUX	V	1 icon	<u> </u>
Funeral Director		5. Social Security Number 132–54–4457	6. Sex 1 ☐ M 2	ו מאו	e (in yrs. ia 5 7	ast birthday) Yrs.	Months Days	Hours Min.		irth Day, <i>Year)</i> 5/1952	Cou	place (State or Foreign ntry) York
and		Usual Residence of Decedent 10a. State 10b. County			10c. City	, Town or Loc	ation					10d. Inside City Limits
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with the a or 28	Director	10e. Street and Number	Daire				10f. Zip Code 2184	۵			zen of What Cou USA	ntry?
death	Funeral	5650 Argyle 11. Marital Status	12. Wa	as Decedent med Forces?	Ever in U.S	S. 13. V	Vas Decedent of H	lispanic Origin? (S an, Mexican, Pueri	pecify Yes or N		14. Race - Amer	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modicel Examinar must be rectified at once.		19a. Informant's Name/Relation: Thaddeus C. Ko	ship (Type Pr sick/s	pouse		19b. Mailin 5650	g Address (Street Argyle	and Number or Ri Dr., Par	ural Route Nurr sonsbur	nber, City o	7 Town, State, Z. 21849	p Code)
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			JOL 11 7003	Morrison 10.	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 241 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Josephine Susanna Logsdon 07 1 Ó 09 1615 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS Braddock Campus **Allegany** Cumberland If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 27 F Months Days Hours 92 Yrs 213-12-9653 Director 12/28/1916 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Medical Exprimer must be notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2 XNo Allegany Ellerslie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 10014 Bottom Street 21529 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify \$ Specify. 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Retail Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) å John Henry Edwards Hazel Madeline Harris 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trau Linda A. Shaffer/ Daughter P.O. Box 132, Ellerslie, MD 21529 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park: 07/14/2009 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, fignature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause or each lin or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transi resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 ☐ Other (specify) the 1 ☐ Yes 2 ZHO 9 Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 1 Tes cate has bage 2 s 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred annedical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Box 68760 P.O. Records, of Vital Division

Hospital or Attending Physician: After this certific funeral director, p within 24 hours after death.

To the Funeral Director: A completely filled in by the fu hours after death. To the I

nds

2

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certific

3 ☐ Suicide

29a. Certifier

32. Registrar's

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 🗌 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complet

6 Could not be

determined

Registrar

			1 - For State Registrar	State of Ma	aryland		artment			nd M	ental H	ygien Reg. N	2111	9	241	23
			Decedent's Name (First, Middle,	Last)							2. Date of I		J.		3. Time of [Death
	Physici		WALTER LEWELL	YN LEWIS							July 1		2009	/ear	6:45	а М
)	/Medic Examin		4a. Facility Name (If not institution,				4b. City,	Town, or	Location of		oury		c. County of	Death	0.45	u
	LAGITIII		2344 Klej Grang	e Road			Pocoi	moke	City	,		V	vorces	ster		
	Funeral Director		5. Social Security Number 214–32–1885			st birthday) '5 Yrs.	If Under Months		If Under 2 Hours	24 Hrs.	8. Date of I (Month, July	Birth Day, Year 10,	934	9. Birtho Cour Perm	olace (State or ontry)	Foreign
П	D .		Usual Residence of Decedent 10a. State 10b. County	10-10-10-10-10-10-10-10-10-10-10-10-10-1	10c City	. Town or Lo	cation								Od. Inside City	v Limits
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	death with the Maryland me 23a or 28e-f ehow rmust be rodified at	Director	MD Worces 10e. Street and Number	ter	Poc	omoke	10f. Zip	Codo				10a C	itizen of Wh	at Cour		
	with a or	ត់		o Dood			218					10g. C	USA		itry :	
	eath	era	2344 Klej Grang	12. Was Decedent	Ever in U.S	3. 13.1			snanic Orig	zin? (Spe	crtv Yes or	No-			can Indian,	
	within 72 hours after death with the Marylan ene. Han "natural", or Itema 23a or 28e-f ehow the Medical Examinat must be notified at	by Funeral	1 ☐ Never Married 2 🗷 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	, orean	1	lf Yes, spec 1 ☐ Yes 2		n, Mexican, Specify:	, Puerto I	ecify Yes or Rican, etc.)			White,		
3	tura	edi	15. Decedent's		war		dent's Usua	I Occupa	ition			16b. I	Kind of Bus			
2	in 72 n "n	Completed	(Specify only highest	grade completed)		(Give	kind of wor DO NOT us	k done di	uring most	of workii	ng	100.				
7	s with iene.	E	Elementary/Secondary (0-12) 12	College (1-4or 5		Mecha	nic					Aut	comoti	.ve		
9	Hyg other	0	17. Father's Name (First, Middle, La	ast)					18. Mother	r's Name	(First, Midd	lle, Maide	n Sumame,)		
ylan	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Ita Mi once.	To B	Walter Lewis	(True Driet)		405 44-05		(7)			Fle				0-4-1	
Ma	12 st hand 7 ten traun		19a. Informant's Name/Relationshi								l Route Nun					
e e	1 and Healt em 2 ther		Mary Frances Lew 20a, Method of Disposition	is (wife)	20b. Pla	2344] ace of Dispo			ge Rd		OCOMO.		Lty, M Location - C			
DEL	Pages nent of h int: If Ite		1 ☑ Burial 2 ☐ Cremation 3		Fast	metery, crer	natory or of	her place	9)			200. 1	LOCATION - C	ity or it	JWII, State	
	t. Partitant		4 Donation 5 Other (Spe		Vete	rans Ce	metery		1/	/15/	2009	Hur	clock,	Ma	ryland	
0	Deports Deports Import		21. Signature of Funeral Service Li	Dean		He 1	ollowa 07 V1	ay Fi ne S	unera treet	1 Ho	me, Pi	rofess e Cit	ional A	Associ	ciation 851	
	hysician		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition	omplications that caused nly one cause on each lin	d the death.	Do not ent	er the mode	e of dying	, such as o	1	r respiratory		17		Approximate Interval Betw Onset and D	veen leath
1	/Medical		resulting in death)	Due to for as	a consequ	ence of):	13 -0	-			1 9				· not	1103
	Examiner		Conventially list conditions	Hy	DET	276	ANOS!	ON	(- 4	185	
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):										
	cuter	Examiner	that initiated events	· KEN	IAL	F	AI	<u>CU</u>	RE					4	392	2
5	be execuicien and burial-tran		resulting in death) Last	Due to (or as	a consequ	ence of:								· ·	- 1	
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8	ndiffica ng pl	Med	IF FEMALE:									- 1				
Š	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1⊟Live birth	of pregnan		Ectopic pre	egnancy					23d. Date			
	e dea he et hed fo	SICI	1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	t time of de		Other (spe					-	Mont	f1	Day Y	ear
ב י	hat the d by t setach	Physician/M	9 ☐ Unknown Part II. Other significant condition		out not carri	lting in the u	ndorhina o		n in Don't		220 Di	d tobacco	uso contrib	uto to t	he cause of de	nath?
cords,	The law requires that the death certificate be executed sets been signed by the ettending physicien and page 2 should be detached for use as the buriat-transit	d by	Tax II. Other signment condition	a contributing to again b		iting in the u		usa giva	minirani.			⊒Yes 2		Prot		nknown
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ב ב	age 2	E			· · · · · · · · ·						pe	topsy rformed?	✓ de	ath?	mpletion of ca	use of
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>	yelci s cer direc	0 8	examiner?	Hospital:	ent 2 🗆 E	R/Outpatier	nt 3 D0	A Othe	-		ne se Re	-	6 □Other	(Specif	6v)	
	Attending Physician: or death. rector: After this certific by the funeral director,	tlon: T	27. Manner of Death 12 Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Da	ırv	28b. Time of Injury		Bc. Injury Work		2	28d. Describ				,	
VISION	death. ctor: A y the fu	flca	3 ☐ Suicide 6 ☐ Could no	ot be 290 Place of Ini	iury - At hor	me farm str					28f Location	(Street a	and Number	or Run	al Route Numb	ner .
2	rs efter al Dire ed in b	Certification:	4 Homicide determin	building, et	c. (Specify))	cot, idetory	, 011100			City or	rown, Sta	te)		2	
:	To the Hospitel or Attency within 24 hours efter death To the Funeral Director: completely filled in by the	Medical	29a. Certifier Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner sta	of examinati	vledge, deatl on and/or in	h occurred a vestigation,	at the time in my op	e, date and inion, death	d place, a th occurre	and due to the	ne cause(e, date ar	s) and man	ner as s	tated. o the cause(s)	
1	To the To the comp	Me	29b. Signature and title of certifier		7		290	. License	number			29d. D	ate signed	(Month,	Day, Year)	
			> /1 (+c	12006	L	7		DA	000	(-1	-		7/14	1/0	9	
			30. Name and address of person w	ho completed cause of d	death (Item	23a) (Type.	Print)		000	7)	0	1	11.	/	-	
B	A5+1		D + (C 1	ans 8th	Stree	t F	DECOM	OKE	בות	00	185	/				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	rar's Signati				, , , ,							
	Registr	ar	JUL 14	2009 12	4	9. 60	wed									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Пау Year **Physician** HENR 1315 LIAM awrence Zoo9 TOLY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL AMBRIDGE on the stee GENERAL CHESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 215-38-0764 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Wes 2 □ No ral", or items 23a or 28a-f sl Examinational be political Funeral Director Easton Talbot 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Ways: 1601 Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify If Yes, Give Year or Dates Completed by 3 ☐ Widowed 4 ☐ Divorced Black "natural". the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) armer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Brooks Clara Chase ပ arrol Mae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millers Road Cordova James Maryland 21625 other t awrence Important: If item 2 any injury or other once, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1/20/09 Shore Cremation Cambridg 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUNERAL Home, P.A. washington St. Cambridge, 23a. Party. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 🔲 Ectopic pregnancy Day in the past 12 months? 1 □ Yes 2 □ No Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2□No 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHBU 31. Date filed (Month, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink Fraue All Copies Are Legible.

Amend Item 23e per phys. G894 Fraue All Copies Are Legible.

Amend Item 23e per phys. G896 10/15/09 ak

Certificate of Death

Reg. No. 1 9 1 - For State Registrat 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 09 0652 **Physician** 2009 July Ramadore Lough /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 29 1935 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Days Hours **Funeral** Months 152 M 2□ F W.VA 74 Director 233-50-4463 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County show od other than "natural", or Items 23a or 28a-f show event, the Modical Examinar a ust be notified at 1 □Yes 2MNo Westminster Carroll Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 21157 USA 1750 Manchester Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1958 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Maryland 21215-0036 1960 2 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Sweetheart Cup Receiving Clerk 6 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked ofth any luly or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Rhoda Perkins Albert Lough ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1750 Manchester Road Westminster, MD Wilma Lough/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 07/20192009 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD Garrison Forest Veterans 21. Signature of Juneral Service Lice 22 Name and Address of Facility Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 leve 23 Part 1. Enter the sease, or complications that clused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or have allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acute Sudden cardiac death **Physician** disease or condition resulting in death) /Medical Due to (or as e consequence of): 1999 Examiner Coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examiner that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Day Year o in the past 12 months? 5 ☐ Other (specify) signed by the sid be detached f □Yes 2□No P.O. 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ ——XE∃Yes 2 □ No 322 Probabily 4 □ Unknown The law requires Hypertension should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Type IIA hyperlipoproteinemia 24a. Was an page 2 s autopsy 1 ☐Yes 2 🛛 No 1 ☐ Yes 2 ☐ No certificate Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? æ Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 XER/Outpatient 3 ☐ DOA ဥ this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After Certification: Division 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation ours after death.

neral Director: A
filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 5 To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier july 10, 2009 D17040 Westminster, MD 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

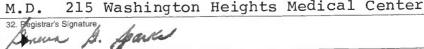
104118

Baltimore.

State Registrar Howard

31. Date filed (Month, Day, Year) 13 JUL

G. Lanham,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 24126

			- For State		Cer	tificate of	Death					eg. No.		
	Physicia		egistrar . Decedent's Name (First, Midd			Date of Dear	Day	Year	3. Time of Death					
edi	cal Examir	ner	SAMUEL JESSE	LADSON							July 20, 2	009		0100 hrs
A am		4	la. Facility Name (if not institution	on, give street and n	umber)		4b. City, Tov		ocation of	Death			unty of Deat ce Georg	
		Ш	Prince George's Hosp	pital			Chever						_	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under Months		If Under Hours	24Hrs. Min.	o. Date of Bit	run (MM/DD/)	C	irthplace (State or Foreign ountry)
	Director		249-34-9983	1X M 2 F	79	Yrs		Lays			2/11/	1930	Di	11on, S.C.
		1 -	Usual Residence of Decedent											10d. Inside City Limits
	v any	-	10a. State 10b. County		10c. City	, Town or Loca	IOII							1 Y Yes 2 No
	daryland 28a-f show 1 at once.	ō 1	Maryland Princ	e George's	s <u>I</u>	andove						On Citizen	of What Co	untry?
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	th the Maryland 23a or 28a-f sho notified at once.		731 Paldao Te	rrace			2078	5	1 0 11	-0/0-1			Stat	erican Indian, Black,
	h with	<u></u>	11. Marital Status 1 Never Married 2 X	A I	cedent Ever in U orces?	I.S. 13. W	es, specify	Cuban,	Mexican,	Puerto R	cify Yes or No lican, etc.)	14.	White, etc.	oriodir inclair, 2.23.,
	r death wi or items must be	Fun		1X Yes	2 No	1	Yes 2 $\overline{\lambda}$	Z No	specify:			Sp	ecify: Bla	ack
	s afte	<u>S</u>	3 Widowed 4 Di 15. Decedent's Education (Sp	or Dates:		16a. Decede	nt's Usual O	ccupatio	on (Give ki	ind of wo	ork done		of Business	
	5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	ompleted	Elementary/Secondary (0-12		(1-4 or 5+)	during r	nost of work	ng life. I	DO NOT L	use retire	ed)	İ		-
	36 hin 72 than edical	흵	12	´		Accou	ntant					Go	vernme	ent
	ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	하	17. Father's Name (First, Middl	e, Last)		1 2 2 2 2 2		1	8.Mother's	s Name (First, Middle,	Maiden Su	rname)	
	ked o	-	Marvin Brown						Jul:	ia M	ae Jon	es		
	21.	6	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailir	ng Address	(Street	and Numi	ber or Ru	ural Route Nu	ımber, City o	or Town, Sta	ate, Zip Code)
	AD 12 shoth th and 127 is umat		Alberta Ladso	n / Wife		731 P	aldao	Ter	race	Lan	dover,	Mary	land 1	20785 or Town, State
	nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f should be the marked other than "natural" and the motified at once other traumatic event, the Medical Examiner must be notified at once	. Î	20a. Method of Disposition 1 X Burial 2 Cremati	on 3 Removal		Place of Dispo crematory or o		e of cerr	netery,		Date	200. 200	Janon - Only	or rown, out
	Pages ent of int: 1		4 Donation 5 Other	Sp@cifv:		arvland	Vete	rans		7/24	/2009	Che	1tenh	am. Maryland
	Baltimore, permit. Pages I ar Department of Hea Important: If ite	1	21. Signature of Funeral Service	Licensee		22.	Name and A	Address	of Facility	Pope	Funer	al Ho	mes,	P.A.
	0 597 [1	Hut a.C	HUEST 7	01085	ro P	ike	Forest	ville	Mar	y1and 20747 Approximate Interval			
	Physician		23a. Part I. Enter the disease, failure. List only one caus	se on each line.							Between Onset and Death			
7	M-dical (aminer	9	Immediate Cause (Final disease	se a. Hyper	tensive	card	liova	ascula	r dise	ease	- Dodin			
			or condition resulting in death)	Due to (or as	a consequence	of):								
		ᡖ	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):								
_		Examiner	cause. Enter Underlying Caus (Disease or injury that initiated	C		of):								-
	ed nsit	Exa	events resulting in death) Las		a consequence									
	xecuted n and l - transit		X UNPENDED	O. AMENDE	23a,27	,perME,	g894	8/3	/09 :	TT				
	760, ficate be exe g physician & the burial -	/Medical	IF FEMALE:		s, outcome of pre							23d.	Date of deliv	very
	8760, ifficate be ng physic as the burn	n/N	23b. Was decedent pregnant ir		e birth		etal death	3	Ectopi	c pregna	ncy	N	onth	Day Year
	Box 68 death certif the attending ed for use as	Physicia	past 12 months?		gnant at time of	death 5	Other (Spec	ify)				ĺ		
	Bo e dear the ar	hys			known	t thing in the	undorlying	001100.0	vivon in Po	art I	23e. Dio	tobacco us	se contribute	e to the cause of death?
	O. that th red by detach	by P	Part II. Other significant con	ditions contributing	g to death but no	resulting in the	undenying	Cause g	given iii r	art i.				Probably 4 V Unknown
	S, F uires an sign Id be	pa						_			24a. Wa	as an	24b. Were	e autopsy findings available
	ord w req	Completed	V									topsy rformed?	prior death	to completion of cause of h?
	Rec The la cate h	E									1 ✔ Ye	s 2 No	1 🗸	Yes 2 No
	al Fian: Sertification, per	e C	25. Was case referred to med examiner?				-		of Death Other				• 🗔	
	Vit hysici this c	To B	1 ✓ Yes 2 No	Hospital: 1		✓ ER/Outpation		OA			g Home 5	Residen		Other:
	n of ing P After funera	٦	27. Manner of Death 1 X Natural 5 P	(Mo	ate of Injury onth, Day,Year)	28b. Time o	or injury		iry at Worl Yes 2	_	20d. Descrit	oe now injui	, 0000	
	ttend death. ctor: y the	äţi		ending vestigation		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	reat factors				28f Location	n (Street an	d Number o	r Rural Route Number, City
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi	Certification:		ould not be	lace of Injury - At	rnome, tarm, s	reet, factory	, once i	Julianig, e	ic.		n, State)		
	Spital spital hours neral	Se	4 Homicide	g Physician: To the			average at the	timo d	ato and al	lace and	due to the c	ause(s) and	manner as	stated.
	he Ho in 24 l he Fu	ca	(Check only one) 2 Medical E	g Physician: To the Examiner: On the bas	best of my knowledges of examination	edge, death oc n and/or investi	gation, in m	y opinior	n, death o	ccurred a	at the time, da	ate and plac	e, and due	to the cause(s)
	To the within To the comple	Medical	29b. Signature and title of cer	and manne	er stated.				se number					(Month, Day, Year)
		ح	Dunget Shouldall MA O.C.M.E.									July	20, 2009	1
		1	pumel.	Withau	UI MY) om 23a\							_	
N	-		30. Name and addre of pers who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, March 111 Penn Street, Baltimore, Baltimo								re, MD 21201			
バ					. Registra s Sign									
		tate	🛮 🗗 . Date filed (Month, Day 💥	n/ 🔏 📴		Ash Kal								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** George Α. Lindenkohl A2516 /Medical acility Name (If not institution, give street and number) Examiner 4b. City, Jown, or Location of Death 4c. County of Death LISbur Hospice at Comico If Under 1 Year | If Under 24 Hrs . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 09/26/1924 Birthplace (State or Foreign Country) **Funeral** 221-14-0906 Months Days Hours Mir Director 84 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, Itm Madical Evantinar mast te poritive 34 Director Maryland Wicomico Salisbury 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30077 Rolling Meadows Road by Funeral 21804 Saltimore Moderator USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or DateMarines 1 ☐ Never Married 2X Married 1 ☐Yes 2X No Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) engineer Dresser Industries 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental George Lindenkohl Maude Phillips ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If Item 27 is Barbara Lindenkohl/spouse 30077 Rolling Meadows Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 7/9/09 Salisbury, MD ure of Funeral Service Licensee and Address of Facility at Home Professional Association Snow Hill Rd., Salisbury, MD 21804 t1. Enter the disease, or complications the Leabled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause an eachline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LUNG CARCINOU MALIC NANT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and trar attending physician ar for use as the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy 1 □Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Tes 2/11√10 Certification: To FOOther (Specify) HOSPICA 1 ☐ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injuly occurred the Hospital or Attending Natural 5 Pendina 2 Accident investigation 1 ☐ Yes 2 🗆 No within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier ompletely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

CutWA State

Registrar

DHMH 17 Rev 1/2001

Hungry

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOX

00058410

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Jean Ann Lanham 9:45 p^M July 10, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Wicomico 102 Reid Street Sharptown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 🔀 F Months Days Hours 213-40-9780 67 Director 04/07/1942 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiliant and bure different once. Director Maryland Wicomico Sharptown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21861 USA 102 Reid Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates Specify à Specify white 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annabelle Jeffreys Jesse Wilson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Reid St., Sharptown, MD 21861 19a. Informant's Name/Relationship (Type. Print) Kenneth Lanham Jr/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hebron Cemetery 7/15/09 4 ☐ Dopathon 5 ☐ Other (Specify) Hebron, MD Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Sign tur-Pay 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Implediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760, nding physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day signed by the aid 5 ☐ Other (specify) P.0. JYes 2 □ No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ğ 1 🗹 Yes 2 🗌 No 3 Probably 4 Unknown page 2 should Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 \(\sum_{\text{Nursing Home}} \) Hospital: 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA al or Attending Physical States death.

I Director: After this in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated. Medical (Check only On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature 454827 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31413 Winterplace

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

Year)

Helman, D.C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene roi State Registrar/MFND#18perINF,7/23/09,BWW,MoCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year July 10, 2009 **Physician** 10:50 P M Jeffrey L. Miller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Montgomery Hospice-Casey House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/08/1953 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 139-40-1799 New Jersey Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expiriting investible and once. 1XYes 2 □ No Funeral Director MD Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20850 USA 2503 Lindley Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry International Banking Elementary/Secondary (0-12) and Finance President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thelma Gelfound Isadore William Miller ပ Etta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Miller-Wife 2503 Lindley Terrace Rockville, MD 20850 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 07/12/2009 Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Edward, Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee في Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Be

Certification: To

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jocelyne Kouatchou, MD

14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

cause. Enter Underlying Cause Disease of injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of Hypertension	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown
		24a. Was an autopsy generated? 1 □ Yes 2 No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6X Other (Specify) Hospice
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1X Certifying Ph	nysician: To the best of my knowledge, death occurred at the time, date and place, ar	nd due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D63748

29d. Date signed (Month, Day, Year)

July 11, 2009

Baltimore, MD 21218

State Registrar 201 East University Parkway

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9,2009 July Honorato Marca 11:55a^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery . Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Days 1**∑** M 2□ F Months Hours Min. 219-21-3105 Peru 89 12/29/1919 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Montgomery Rockville Director 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 13209 Justice Road 20853 Peru Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🙀 Married 1√Yes 2□No Yes Give Specify: Peruvian White þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sabino Marca Demetria Cueto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilfredo Marca/Son 5610 St.Charles Drive Woodbridge, Va. 22193 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 7/13/2009 Silver Spring, Md 5 ☐ Other (Specky) Funeral Service Lice 21. Signature PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastric adenocarcinoma Due to (or as a consequence of): Gastric hemmorhage Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a consequence of) Hypotension Due to (or as a consequence of): Shock liver 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 ☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gastro intestinal bleeding 1 Yes 2 No 3 Probably ★ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Acute renal failure 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner 68760, Box o ۵. Records, Vital Honorato of Division

physician and the burlal-transit pe attending p signed by the a d be detached f law requires that the page 2 should been has certificate director, Phospital or Attending P 24 hours after death.
Funeral Director: After the telety filled in by the funera 24 hours a npletely

Physician

/Medical

Examiner

Funeral

Director

ed other than "natural", or Items 23a or 28a-f shevent, the Medical Examiner must be notified

marked other

2 should be fi

1 and 2 Health a

permit. Pages 1
Department of Hi
Important: if iten
any injury or oth

Physician

/Medical

Examine

Physician/Medical

Be

Certification: To

Medical

72 hours after

Maryland 21215-0036

Baltimore,

6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of certifier,

Súdarshan

onth, Day, Year)

(Check only one)

31. Date filed (M

SUDARSHAN SUA

Registrar's Signature

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

D653/Z

8600 Old Georgetown Road Bethesda, Md

nd address of person who completed cause of death (Item 23a) (Type, Print) Siva M.D.

State Registrar

within 2

			For State Registrar	State of Marylan		ertificate of L			giene 2 Reg. No.	009	24131
	Physici		1. Decedent's Name (First, Middle, Las Timothy	Jude	McGr	eevv		2. Date of Dea Month 07	Day	Year 09	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	07		Inty of Death	1
1	=xa		WMHS-BRADDOCK	CAMPUS		CUMBERI			ALI	LEGANY	
	Funeral Director		5. Social Security Number 6. S 218-38-0520	V M 2□F	<i>last birthd</i> ay Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)		place (State or Foreign intry)
	D		Usual Residence of Decedent	67				12/23/1	941	Mar	yland
	arylan show d at	'n	10a. State 10b. County MD Alle		y, Town or L		3				10d. Inside City Limits 1 □ Yes 2 ☑ No
	the Mi	Director	MD Alle	garry		Cumberland	1		10a Citizen	of What Cou	
	3a or	al Di	11617 Zennia A	venue		21502	2		USA		,
စ္	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Evarrier coust be rectified at once.	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 No 195 If Yes, Give	s. 13	. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 ☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,	etc.
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altimore, Maryland 21215-0036	within 72 t ene. than "nati	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	ducation (de completed) College (1-4or 5+)	(Giv	edent's Usual Occupa re kind of work done d DO NOT use retired, Electric	luring most of work)	ing		of Business/Ir	ndustry
q 5	filed \ Hygid	Be Co	17. Father's Name (First, Middle, Last)			ETECCLIC.	18. Mother's Nam	e (First, Middle,		Union name)	
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lar∫	2 short and I short Is ma		19a. Informant's Name/Relationship (I	ling Address (Street a			-		
e)	1 and Heatth em 27 ther t		Lana D. McGreevy 20a. Method of Disposition			617 Zennia		Cumber		MD 2 on - City or T	1502
timor	Pages tment of tant: If it		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	nberla	position (Name of ematory or other place and Cremato	ory 07/20	/2009	Cumbe	erland	, MD
Ba	permit Depar Impor any In		21. Signature of Funeral Şervice Licer	District Control of the Control of t		22. Name and Addres			-		Home, P.A. 21502
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,	/Medical Examiner	<u>.</u>	resulting in death) Sequentially list conditions.	U.	20	CUBINS	· ULCON	LIN B	UTTO	CK.	1 month
	cuted id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	dence or).						
Ö,	oe exec sian ar urial-tr	Ex	that initiated events resulting in death) Last	Due to (or as a consequence	uence of):						
68760,	icate t physic the b	edical		d							
.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	death 3	☐ Ectopic pregnancy ☐ Other (specify)	/		23d.	Date of delive	very Day Year
rds, P.	w requires that been signed be should be deta	þ	Part II. Other significant conditions of	•	-			23e. Did to			the cause of death?
Division of Vital Records,	The law re ate has be page 2 sho	Completed						24a. Was autop perfo 1 □ Yes		4b. Were aut prior to co death?	opsy findings available ompletion of cause of
Zi za	ıysiclan: The iis certificate h director, page	Be (25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Deal	h (Check only o	ne)		
o	iding Phys th. After this (funeral dir	6	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpati 28b. Time		4 LI Nursing Ho	ome 5 Residence 128d. Describe h			ify)
<u>o</u>	nding ath. r: Afte e fune	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury		? Yes 2 □ No				
Divis	or Attencate after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, s fy)	treet, factory, office		28f. Location (5 City or Tox	Street and No vn, State)	umber or Rui	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C		nysician: To the best of my kno niner: On the basis of examina and manner stated.	tion and/or	investigation, in my o	pinion, death occur	red at the time,	date and pla	ice, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and the of certifier	PHYSICIAN	/	29c. License	e number		29d. Date si	gned (Month	, Day, Year)
	3+		1/ //	J' / Si Crio	-	ν	0844		07	1/20	100
	nds		JOSE	completed cause of death (Item	n 23a) (Type	Print)	912 Sitton	PRIVE	eum	Bines	, Day, Year)) / O.G AND MP ZiSOZ
Ī	Sta Registr	_	31. Date filed (Month, Day, Year) 2009	32. Registrar's Signa	face	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Maxwell-Spieth 9:39 A M Martha Jane 2009 10. July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges The Collington Mitchellville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗑 F 86 218-12-7412 Director 04/30/1923 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location rthan "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 10a, State 1 ☐ Yes 2 ☑ No Allegany Cumberland Direc 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21502 13207 Bedford Road, NE Funeral 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Item ury or other traumatic event, I'm Medical Examinary or other traumatic event, I'm Medical Examinary. 1 Never Married 2 Marned 1 ☐ Yes 2 No 1 ☐ Yes 2 🛱 No Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Professor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Orr Jessie Leone Anderson Thomas Fitch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13207 Bedford Road, NE, Cumberland, MD 21502 Barbara E. Maxwell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Cumberland Crematory 07/12/2009 Cumberland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🛱 No 3 ☐ Probably 4 ☐ Unknown Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipidemia page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) ဥ

/Medical Examiner

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The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital Hospital or Attending Physician:

with the Maryland

death

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 💢 No 27. Manner of Death

1 XNatural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certif

29c. License number D47603 29d. Date signed (Month, Day, Year) July 10, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William F. DuBoyce, M.D., 12158 Central Avenue, Mitchellville, MD

State Registrar



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1 - State of Maryland	-	rtment of He			ene 2 0 0 9	24133
			1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		ALICE M. MARKER					16 Year	0510 M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death		4c. County of Deat	h
			WMHS Braddock Campus		Cumber	cland		Allega	ny
	Funeral	Υ.	5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)		If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day,	9. Birti	hplace (State or Foreign untry)
	Director		236–18–5050 1□M 2XF 89	Yrs.	World Days	O	7/01/192	20 WEST	VIRGINIA
	pu "		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	action				10d. Inside City Limits
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	vith t	늄	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	untry?
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	er de item	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 2 No	s. 13. V	Vas Decedent of Hisp f Yes, specify Cuban,	Mexican, Puerto R	ican, etc.)	14. Race - Ame Black, White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Exeminer must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No If Yes, Give 1		∐Yes 2√∏ No	Specify:		Specify: WIT-	HITE
ò	tura		15. Decedent's Education	16a. Deced	lent's Usual Occupati	on	16	6b. Kind of Business/	
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212	l withir jiene. r than	E	Elementary/Secondary (0-12) College (1-4or 5+)	HO	MEMAKER			HOME	
b	filed II Hyg othe	BeC	17. Father's Name (First, Middle, Last)		1:	8. Mother's Name	(First, Middle, Ma	aiden Surname)	
Maryland	ald be fenta rked ric ev	10 B	MARTIN BRENNAN			PEARL (U	NKNOWN))	
ary	shou and N s ma	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street and	d Number or Rural	Route Number, (City or Town, State, 2	Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at		LINDA HOEY / COUSIN	P.	o. BOX 676	FORT A	SHBY, WV	7 26719	
<u>e</u>	Item			ace of Dispo	sition (Name of natory or other place)	Da	ite 20	Oc. Location - City or	Town, State
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Baltimore,	permit. Pages 1 Department of P Important: If Ite any injury or ot		21. Signature of Funeral Service Licensee		Name and Address UPCHURCH	·	TIOME TN	TO.	
m	Depar Depar Impor any ir		Kondy Il. Lenchure	16)	P.O. BOX	1260, FO	RT ASHBY	V. WV 267	19
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0.	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	Physician/Me	1 Tyes 2 No 4 Pregnant at time of de	eath 5□	Other (specify)			Month	Day Year
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Vital Records,	w requir been s should	Completed					1 Ll Yes	2 □ No 3 □ Pr	obably 4 Unknown
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/ita	Physician: The this certificate al director, pag	Be (25. Was case referred to medical examiner?			26. Place of Death	(Check only one))	
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u		:uo	27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	28b. Time of Injury	Work?		Bd. Describe how	injury occurred	
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Division	or At after d Direct in by	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At homicide building, etc. (Specify	me, farm, stre	et, factory, office	28	Bf. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
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7	4		20. Name and address of source who completed source of death (III)	229\ /Ti	Print)	1001	1	744	
	Notell		30. Name and address of person who completed cause of death (Item	4 S	fron Dri	VP PI	rebert	and M	16,2005 D 21502
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		For State Certificate of Death Reg. No.											_					
Physicia		1. Decedent's Name											Date of Dea Month	Day	Year		ime of Death	
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Baltimore, MD 21215-0036 cermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho njury or other traumatic event, the Medical Examiner must be notified at once		1 X Burial 2			emoval f	rom State		matory or ot		17-1	ndc	7/27	7/2000	Port	- Par	nuh1	ic. MD	
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Baltimore, MD permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is injury or other traumat	J	H- 6	2:1	1					. O. I									-
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tal Recor	S	25. Was case refer	red to medica	al					26.	Place	of Death (Check or	nly one)					_
Vital Rec ysician: The his certificate director, page	Be	examiner?		Hospi	tal: 1	Inpatient	2 E	R/Outpatien	t 3 DOA	, - J	Other:	Nursing	Home 5	Residence	6 🗸 0	Other: S	cene	7
ing Phy ling Phy After th	ို	1 ✓ Yes 27. Manner of Dea	2 No	_	28a. Dat	e of Injury	. 2	28b. Time of	Injury 280	. Injur	y at Work'	? 2	8d. Describ	e how injury	occurred			Т
on ding	흲	1 Natural		ding		th, Day,Yea 7 / 20 /		Fd 10:	39 am	Y	es 2X	No	unk					
Signature of the state of the s	S	2 Accident		estigation					eet, factory, of	fice bu	uilding, etc	c. 2	28f. Location	(Street and	Number o	or Rural	Route Number, Cit	y
Division of Vital pital or Attending Physician ours after death. eral Director: After this cerifilled in by the funeral directon.	Certification:	3 Suicide 4 Homicide	6 XX Cou	ermined	(Specify	hou	ise					I.	or Town	State) Z.3. Calif	ZZU 1 Ornia	Surr a, M	Route Number, Cit ey Way D	
E 8 5		29a. Certifier (Check only	Certifying F	hysician:	To the be	est of my k	knowledae	e, death occu	rred at the tir	ne, da	ite and pla							
To the Hos within 24 h To the Fun	Medical	one) 2	Medical Ex	aminer:On	the basis	of exami	nation and	d/or investiga	ation, in my or	oinion,	, death oc	curred at	the time, da	te and place,	and due	to the o	ause(s)	
To COL	Me	29b. Signature and	title of certifi		l manner	sialed.			29c. L	icense	e number			29d. Dat	e signed	(Month	, Day, Year)	
		Daniel	A OK	Ala.	11 0	M				D.C.N	M.E.			July 2	1, 2009	9		
		30. Name and add	ress of merso	n who com	oleted car	use of dea	ath (Item 2	(3a)										_
		Pamela E.	Southall, I	MD As		t Medic			11 Penn S	treet	i, Baltim	ore, M	D 21201					
S+	ate	31. Date filed (Mor	th_Day,Year			Registrar's	Signature		,									_
			ate filed (Month, Day, Year) 32. Redistrar's Signature A. Sparks															

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2:25 A.M 07 2009 BOYD 21 AYERS MASON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALLEGANY CUMBERLAND ALLEGANY NURSING & REHAB CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 10/29/1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 215-14-6511 87 Director MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show The Madical Examiner must be notified at 1 XYes 2 □ No **ALLEGANY** CUMBERLAND MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 15 CUMBERLAND STREET U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry GENERAL SERVICES other than Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATION ENGINEER & DRAFTSMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fit and Mental His markad ot permit. Pages 1 and 2 should be Department of Health and Mental Important: If Itam 27 Is marked t any injury or other traumetic avegate. LOVOTA ELLA AYERS DAVID W. MASON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 RAYNE DRIVE, CUMBERLAND, MD 21502 C. EUGENE MASON / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) M.S.V.C.-ROCKY GAP 07/28/2009 FLINTSTONE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNÉRAL HOME, P.A. schurch 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Pant1. Enter the distrise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Discore Immediate Cause (Final disease or condition resulting in death) Covon /Medical Due to (or as a consequent of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manger of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 2 July 21,2009 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) Cumberland. 625 Kent 21502 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 Sarked

Physician Examiner

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Olive Pearl Marks July 19. 2009 /Medical 8:15A 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Memorial Hospital 9. Birthplace (State or Foreign Cumber land 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 92 Yrs. Director 232-60-5433 12/27/1916 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Directo MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 13417 Brice Hollow Road 21502 "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic event, Ihe Modie once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah David Twigg Margaret-Brotemarkle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Marks / Son 13501 Brice Hollow Road, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park | 07/22/2009 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Ineu mon wech disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendant about a control of the c attending physician and for use as the burial-traresulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Division of Vital 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1. Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

na State

3

31. Date filed (Mo Registrar

29b. Signature and title of certifier

Sunil Gupta, M.D., 625 Kent Avenue, Cumberland, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DO0 33280

29d. Date signed (Month, Day, Year)

2009

July

21502

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Hagerstown

Days

3. Time of Death

Birthplace (State or Foreign Country)

10d Inside City Limits

Approximate Interval Between Onset and Death

nostle

Day

Year

1 □Yes 2¶No

4c. County of Death

8. Date of Birth

14,1913

Washington County

Virginia

White

2:45 A M

7. Age (In yrs. last birthday)

10c. City, Town or Location

95

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

10b. County

6 Sev

1 M 2 TF

NMS of Hagerstown

5. Social Security Number

214-09-4266

Usual Residence of Decedent

Funeral Director

with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Physician /Medical Examiner

burial-transi the attending physician as the t been signed by i should be detach the Hospital or Attending Physician; funeral director. within 24 hours a er deatl To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

Maryland Washington County Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13816 Old Maugansville Rd. 21767 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 2 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 Hosiery Company Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 489 Goodview Dr. Hedgesville, WV 25427 David Mummert-son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Broadfording Church Cemetery Crematory or other place) Cemetery 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7-20-2009 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 la Dun 23a. Part1. Enter the disease, or complication, that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Dthknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural
2 Accident Iniury 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check dnly one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) etam Stock HAG MD21740

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Montl

VH-10

Physician	1
/Medica	l
Examine	l

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Modical Exacult or inviting an once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

WH-5 Sta Registr

	1 - For State Registrar		Olalo o	· ····································	Ce	rtificate		ath		Reg. No.	2009	24138
	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death										3. Time of Death	
an	Irma Ruth Mowry						July			5 Day	2009 Year	8:48 P M
al er	a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death 4c. County of Death						
•	4000 *********								hinoto	n County		
-	5. Social Security Number	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)				Hagerstown yi If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months, Davs Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country)						
	578-28-5658 1□M 2XF 89 Yrs.					y If Under Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. May 25, 1920 Penn.						sylvania
	Usual Residence of Deced											
_		County			ty, Town or Lo	ocation						10d. Inside City Limits
용	Maryland Was	hingt	on Coun	ty Hag	erstow	m						1 ☐ Yes 2 No
Ş	10e. Street and Number					10f. Zip Co	ode			10g. Citize	en of What Co	untry?
le.	1202 Hillbr	ook D	r.			21742				U.S.A.		
<u>ne</u>	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								D- 14	14. Race - American Indian, Black, White, etc.		
五	1 Never Married 2	1 Never Married 2 Married 1 Tyes 2 No If Yes, Give Year or Dates: 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business.										
d b	3 ☐ Widowed 4 ☐ D									Specify. WII.	irte	
Be Completed by Funeral Director	15. Do (Specify only									d of Business/I	ndustry	
Id I	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 (Give kind of work done during most of working life. DO NOT use retired) School Teacher Board of Education									1		
S					Schoo	1 Teac						ducation
Be	17. Father's Name (First, I)				l.		e (First, Middle			
မ	Sherman G.	Amick						<u>Stella</u>	Hanks	<u>Amick</u>	:	
	19a. Informant's Name/Re	elationship (Type. Print)		19b. Maili	ing Address (S	Street and N	lumber or Ru	ral Route Numb	er, City or	Town, State, Z	Zip Code)
George C. Mowry-husband 1202 Hillbrook Dr. Hagerstown, MD 21742												
	20a. Method of Disposition 1 X Burial 2 ☐ Cren		Removal from	State 20b. I	Place of Disper cemetery, cre	osition (Name matory or othe	of er place)	1	Date	20c. Loc	ation - City or	Town, State
	4 Donation 5 □C			Re	st Hav	en Ceme	etery	7-18-	-2009	Hager	stown,	MD
	4 Donation 5 Other (Specify) Rest Haven Cemetery 7-13-2009 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home											
	1331 Eastern Blvd. North Hagerstown, MD 21742											
1	23a. Part1. Enter the shock or hear failur	23a. Part 1. Enter the isease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										Approximate Interval Between
	shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition a CACATIVE HEAVET FALLEE									Onset and Death		
	disease or condition resulting in death) a. Due to (or as a consequence of):											
			ATH	FROSC	IFROM	70 (ARA	IOVAG	CUGAR	Nis	BASE	YEAR (C
Jer	Sequentially list conditions if any, leading to immediat	conditions, immediate b. ATHEROSCUEROTIC CARD OVASCULAR NUSTAIN Due to (or as a consequence of):										
Ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c											
Ä	resulting in death) Last	- 1	Due to	(or as a consec	uence of):					-		
Medical Examiner		•	d									
led												
N.	IF FEMALE: 23b. Was decedent pregn	ant		tcome of pregnation		☐ Ectopic pre	700001			23	3d. Date of del	ivery
icia	in the past 12 month 1 ☐ Yes 2 ☑ No	s?		nant at time of		Other (spec					Month	Day Year
hys	9 Unknown		9 🗆 Onkr	iown								
Ϋ́	Part II. Other significant of	conditions	contributing to d	eath but not res	ulting in the u	underlying cau	se given in	Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
edt	PARDXYSI	772	ANUI	72 h	RILLA	MON	1		1 🗆	Yes 2	Mo 3⊟Pr	robably 4 🗆 Unknown
Be Completed by Physician/I	HYDERT	5250	\sim	XEME	NTA		,		24a. Was		24b. Were au	topsy findings available
mo	autopsy performed? performed? death?											
O	25. Was case referred to r	medical	1				26	Place of Deal	1 ∐Yes th (Check only	2 No	1 □ Yes	2 🗆 100
	examiner? 1 ☐ Yes 2 ☐ No		Hospital:	Inpatient 2	FR/Outnatie	nt 3 □ DOA	Other:	☐ Nursing H			☐Other (Spe	cifu)
Ë	27. Manner of Death			of Injury th, Day, Year)	28b. Time o		I . Injury at Work?		28d. Describe			Uny)
Ē	Natural 5 ☐ 2 ☐ Accident	Pending investigatio		th, Day, Year)	Injury	M	Work? 1 ∐Yes	2 □ No				
fice	3 Suicide 6 🗆	Could not b	28e. Place	of Injury - At h	i ome, farm, st	reet, factory, o	ffice		28f. Location	(Street and	Number or Ru	ıral Route Number,
erti	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
al C												
Medical Certification: To	2 / 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. Description of the cause(s) and manner as stated. And manner stated.											to the cause(s)
Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										h, Day, Year)	
	1 1 Tal Regulard - 1/12/09											
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JU ITE /3 HAGERS 70 WN											
Partie A FOX BARKET MA IND MATICAL CAMPUT DX MX 21716											31743	
ie.	31. Date filed (Month, Day			Registrar's Signa	ature [1	HOIG	016/1	(17	11.01	<u> </u>	1 13 0	X1/7.2
ar	111		2000		1	had!	•					

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month July 13, 2009 **Physician** Mitchell 12:15AM M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NMS Healthcare of Hagerstown Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 20, 1951 Birthplace (State or Foreign Country)
 DC 7. Age (In yrs. last birthday) **Funeral** 15€M 2□F 578-94-7889 57 **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location rthen "naturel", or Items 23a or 28a-f show the Modical Examiner must be notified at XX Yes 2 □ No WASHINGTON Hagerstown Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 14014 Marsh Pike 21742 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) other then UNEMPLOYED 9th UNEMPLOYED 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if tiem 27 is marked othing only injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Sadie Bexum Rufus M. Mithcell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sadie Mitchell/Mother 13216 Fox Bow Dr #308 Upper Marlboro, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-16-2009 Laurel,MD * 4 ☐ Donation 5 ☐ Other (Specify) Maryland National page and Address of Facility John T Rhines FUneral Home LLC 21. Signature of Funeral Service Licen -e Juan Smith 12th Street NE Washington, DC 20017 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Gliobas Physician /Medical Due to (or as a consequence of) Examiner Rual Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SOAparni & 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 □ Nô Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Horning Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 MURSHED ARID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 5 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Malone Doyce 10:50 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore LMMS 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC . 26 9. Birthplace (State or Foreign Funeral 6. Sex 7. Age (In yrs. last birthday) Days Min. 1□M 2√F 44 WASHINGTON, DC Director 212-02-1936 1964 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Expressions to be put it and the context. 1 ☑ Yes 2 ☐ No Director MD PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7522 WILHELM DRIVE 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No BLACK 2 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH GOVERNMENT BUS DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KELLEY JAMES BARBARA SLOAN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MALONE/HUSBAND PAUL 7522 WILHELM DRIVE LANHAM, MARYLAND 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 7/21/2009 CLINTON, MARYLAND 4 Donation 5 Dother (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, o shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final metastatic nonsmall cell lung **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death), leat Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 ☐ Yes 2X No 1 ☐Yes 24 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1, Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation death. 1 ☐ Yes s after death. 2 No 2 Accident completely filled in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of corting NPI 1063671105 ress of person who completed cause of death (Item 23a) (Type, Print) SS4-faul, MD Balkmore, MD 21201 22 S. Creen Sheck 32. Registrar's Signature (Month, Day, State Registrar

amend #7 Per FH G894 8/11/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 10, 2009 **Physician** William Adam Nicol 4:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte Hall | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May | 7, 1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 □ F 79 80 381-24-6714 Michigan Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show a or 28a-f show t be notified at 1 ☐ Yes 2 ☐ No ST. Mary's Director Maryland Charlotte Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 29449 Charlotte Hall Road 20622 USA permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specify <u>م</u> If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Waterbury Farrel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Nicol ၉ Agnes Weir 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Carlson/Daughter 10708 Javins Street, Glenn Dale, MD 20769 20a. Method of Disposition
1 □ Burlal P □ Seremation 3 □ Removal from State
4 □ Donatish 5 □ Dther (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 13,2009 Charlotte Hall, MD Brinsfield-Echols Crem. 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signat Funeral Service Licensee M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mons **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as the attending p 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9□Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 2 ☑ No Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 NO Certification: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after dea To the Funeral Director filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 Tame and address of person who completed cause of death (Item 23a) (Type, Print) 12200)avaKoli 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 14 2009 Registrar

ORIGINAL

State Registrar

East

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Martin

1 JUL

Jarelle 31. Date filed (Month, Day, Year) MO

D67763

Hugerstown

Street

2009

21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:18 AM 15 2009 JULY CYNTHIA LOUISE NUGENT /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S HOSPICE OF QUEEN ANNE'S HOSPICE CENTER CENTREVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Months Days Hours JULY 19, 1 □ M 2 🕱 F INDIANA **Director** 309-66-4908 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Exa. discrintal barrolithed at 1 XYes 2 No Director QUEEN ANNE'S CENTREVILLE **MARYLAND** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 502 LITTLE KIDWELL AVENUE 21617 Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No 14 Race - American Indian. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give Year or Dates: 1977–1987 \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE NURSING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be HELEN LOUISE LUDWICK ည JOSEPH SCOTT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 502 LITTLE KIDWELL AVENUE, CENTREVILLE, MD 21617 ROBERT P. NUGENT/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON
NATIONAL CEMETERY Date 20c. Location - City or Town, State 20a. Method of Disposition SEPT 14 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2009 ARLINGTON, VIRGINIA 21. Signature of Funeral Sprvice Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line Immediate Cause (Final disease or condition resulting in death) **Physician** CVA /Medical Due to (or as a consequence of) Examiner APlasia RED coll Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Prometo and -trar Due to (or as a consequence of): physician a P.O. Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? certificate 2 No 1 ☐Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural after death. Director: Af 1 ☐Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 6374 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar JEFFRE,

31. Date filed (Month, Day, Year)

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OPIGI

32. Registrar's Signature

VICENS

2740 Congravilla Ross Confraille

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Naff Month O7 Pauline Stella 2009 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death Vear If Under 24 Hrs. comico castal Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. las Months Days Min. 1 □ M 2 🛭 F Hours 212-34-9182 72 08/02/1936 Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Maryland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 50 Teal Circle USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No If Yes. Give Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) cook food service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Glinowiecki Victoria Lorenze 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Mattingly/daughter 50 Teal Circle, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/14/09 Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Signature of Funeral Service Licensee 22HOTTOWAY Fundral Home, Professional Association 23a. Part 1. Enter the risease, or commissions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MAHONAN LUNG CARCINOUNA Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FINO 3 Probably 4 Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 No Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICIZ 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Examiner executed and burial-tra Box 68760. attending physician requires that the death certificate be the as signed by the a P.O. Division of Vital Records, icate has been significate page 2 should b certificate To the Hospital or Attending Physician:

After this certific funeral director, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination in ust be notified at

Physician

/Medical

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PO

32. Registrar's Signatur

BOX

Baltimore, Maryland 21215-0036

boline

State Registrar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0058400

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

7/13/09 Amd Box 1 per FD crw, Amend Item 1 per dr.,g893,07/31/09dhb Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Joseph North, Jr. Worth 2. Date of Death Time of Death **Physician** 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Feb. 6, 1928 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ₩ M 2 □ F 81 NJ 156-20-3585 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at Sykesville 1 ☐ Yes 2 ☐ XIo MD Carroll Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 once. 7200 Third Avenue 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Product Manager Building Materials 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Davidson Joseph North P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Silverstrand Place, The Woodlands, TX 77381 Mr. Daniel D. North (Executor) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 7/13/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mocros PO Box 195 Sykesville, MD 21784 Hallay Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACCIDENT **Physician** CEREBROYASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if a y leading to include cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. ed by the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy perform certificate 2 XNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After this funeral of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural Injury To the Hospitai or within 24 hours after death.

To the Funeral Director: After a manufately filled in by the further or the further and the f 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) July 10, 2009 29c. License number **D** 0017695 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDALLAH J. HELOU, M.D. CARROLL HOSPITAL CENTER, WESTMINSTER, MD 21157 Can 31. Date filed (Month, Day, 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death J_{u}^{Month} 9, 2009**Physician** 12:35 NP John Martin Olsen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Charlotte Hall CHARLOTTE HALL VETERANS HOME | Months | Days | Hours | Min. | September 9,19 | 16 | Continuous | Min. | September 9,19 | 16 | Continuous | Min. | September 9,19 | 16 | Continuous | Min. | September 9,19 | 16 | Continuous | Min. | September 9,19 | 16 | Continuous | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 92 Director 578-12-3195 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f show Director 1 ☐Yes 2 No ST. Mary's Charlotte Hall Maryland 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, its Modern Examination to 12. USA 20622 29449 Charlotte Hall RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2X No Specify: Completed by 3 Widowed 4 □ Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working jife. DO NOT use retired)
Television Repairmen Elementary/Secondary (0-12) Sears and Robuck College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary E. Sanner Harry Olsen 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 100 Marborough Rd., Queenstown, Howard Payne/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State July 20, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Qther (Specify) Maryland Veterans Cem. 2009 Cheltenham, MD 21. Si matrie of Funeral cervice Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., M00817 30195 Three Notch Rd., Charl 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 30195 Three Notch Rd., Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** allure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ah Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-transi that initiated events resulting in death) Last neumonia Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☑No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 167814 9/09 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCISA BRUNEY
vate filed Whith Day, vear)

DHMH 17 Rev 1/2001

State Registrar

CHARLOTTE HALL

29449

32. Registrar's Signature

CHARLETTE

20622

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 **Physician** Wilma Ann Olson 1:09 Pm 12, July /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City. Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 T F 91 577-01-9093 Director 04/30/1918 Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Evaruiner must be notified at MD Prince George's 1 ☐ Yes 2 No Director Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2601 Fairlawn Street 20748 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Server Food Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Jacob Wirz Marie Kifferie ဥ 19a. Informant's Name/Relationship (Type. Print)
Albert Olson (son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, MD 20901 11234 Legato Way 20b. Place of Disposition (Name of cemetery, crematory or other place).
Arlington National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State August 31, 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Arlington, 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. " M01464 John F. Holmes 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Intarisio **Physician** O (a/di disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 1 □ Yes 1 ☐Yes 2 ☐ No 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ieral Director: A filled in by the fu 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Den

within 24 hours a

P.O. Box 68760,

Division of Vital Records,

State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

Jank Ku

30. Name and address of person who completed cause of death

32. Registra s Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

CleAN Dale MS 20769

Nadel lavalo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 9:49 PM Mary Lou Peterson 9 2009 JULY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hagerstown Washington Washington County Hospital 8. Date of Birth (Month, Day, Year)
Dec. 29,1930 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖫 F Michigan 78 Director 374-28-9855 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the fredical Examples of profitting any injury or other traumatic event, the fredical Examples of page. 1 ☐ Yes 2 X No Director Franklin Fayetteville PA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17222 United States 6398 Fairway Drive West by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 27 No Specify: Specify: White 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Work Social Case Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dale L. Palm Audrey V. Bishop ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6398 Fairway Drive West, Fayetteville, PA 17222 David J. Peterson / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 18 2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Grand Rapids, Michigan Rosedale Memorial 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALTERED **Physician** MENTAL disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** SEIZURE BISOKBGR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner RESPIRATORY Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 3 Ectopic pregnancy Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🎇 No 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🕅 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760.

3 Suicide

4 Homicide

29a. Certifier (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

HALL GRESTONIU

9b. Signa	ature and	l title of c	ertifler	
		1/5	100	
		V	7	

10067006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTIETTIM ST.

MO

State Registrar

Medical

31. Date filed (Month, Day, Year) 14

251 WIRSOU 2. Registrar's Signature

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:45 A M Ju1y 2009 Lucille Elizabeth Pilkerton 11, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chesapeake Shores Nursing Center St. Mary's Lexington Park If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🔀 F 216-30-4497 77 March 18,1932 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Mechanicsville 1 ☐ Yes 2 No St. Mary's Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20659 USA 27870 Old Village Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐Yes 2 ☑ No Specify. ۾ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Telephone Company 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Graves Richard Buckler ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27870 Old Village Road Mechanicsville, MD 20659 Larry Pilkerton / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Joseph's 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State July 15, 2009 Morganza, Maryland 4 Donation 5 Dother (Specify) Catholic Cemetery 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as Ardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Due to (or as a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Examiner Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions conditions to de þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 # Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1-II Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident

law requires that the death certificate be executed Box 68760 P.0. Records, Division of Vital

physician and s the burial-tran and as attending plant for use as signed by t 1 be detach page 2 should been has certificate funeral director. this vor une Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in tw the.

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modell Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

the Maryland



State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY **Physician** ľ4, 2009 3:30 P.M. Joan Marie PITSNOGLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Reeders Memorial Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 18 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days ^{Year)} 1934 Hours Min 1 □ M 2 🛛 F Maryland 74 Director <u> 219-44-3629</u> Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Experience must be rediffed at 1X Yes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 113 W. Wilson Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Specify. \$ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 Homemaker Her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Roy Harrison Reed Pearl Alberta Lum 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly L. Pitsnogle - Son 20148 Toms Road, Boonsboro, Maryland 21713 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Itel any Injury or otl once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park: 7/18/09 | Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home +415 E. Wilson Blvd. Hagerstown, Maryland 21740 mules 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kenal **Physician** paclene Lweek disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Yours Kedvey Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of YEARS. Diascles Millely been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical YEARS neut anolon IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician:
-within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) g and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2009 MD 4656 edu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21713 301-432-8470 20311 LAPPANS ROAD, BOONSBORO, DR. GHAZALA QADIR, 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

DHMH 17 Rev 1/2001

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er de items	Funeral	11. Marital Status1 □ Never Married 2 □ Mar	Armed F		1.5.	If Yes, specif	y Cuba	ispanic Or an, Mexica	in, Puerto l	cify Yes or No Rican, etc.)	0-		White, e		
", Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. Tris marked other than "natural", or items 23a or 28a-f show no 72 is marked other than "natural", or items 23a or 28a-f show in traumatic event, the Medical Examiner must be notified at	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, G	2 █ No Bive Dates:	i	1 ☐ Yes 2	∑ No	Specify.				Specify: W	hite	2	
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On C ling F After funera	ion:	27. Manner of Death 1 Matural 5 ☐ Pendi		nth, Day Year)	28b. Time Injury	or 28	Bc. Injui Wot	ryat k? Yes 2 [Ι.	28d. Describe	now inj	ury occurred	i		
Division or Vital Records, or Attending Physician: The law requires tafer death. Director: After this certificate has been signed in by the funeral director, page 2 should be	icat	3 Suicide 6 Could	not be 28e. Pla	ce of injury · At h	nome, farm, s			103 2		28f. Location	(Street	and Number	or Rura	Route Number	er,
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Division or Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but			ing Physician: To t												
he Ho in 24 he Fu	Medical	one)	I Examiner: On the and ma	anner stated.	allon and/or					red at the time	e, date a	ind place, an	a due to	trie cause(s)	
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÷ st	ate			Registrar's Sign		0 7 2	- / -	- / ·	, , ,	7-100-16	-N-J	///	V	-1)00	
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amend #9,17&19a Per H 6894 8/06/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 07 **Physician** 2009 9 PM M Jeanne Rutenburg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges 7805 Vanity Fair Drive Greenbelt If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 11-17-1950 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 X F 58 a Mass. 025-36-9036 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the treatest Experient trust by notified at 1X Yes 2 No Director MD Prince Georges Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --:- any injury or other traumatic eventations. 20770 **USA** 7805 Vanity Fair Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married White 1 ☐ Yes 2X No Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College 5+ Professor 17. Father's Name (First, Middle, Last)
Rutenburg 18. Mother's Name (First, Middle, Maiden Surname) Be Selma Hyde Alexander ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's kemer Belationship (Type. Print) Selma Rutenberg '/ mother 65 East India Row, Boston, MA 02110 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/14/2009 Boston, MA Stepiner Cemetery 22. Name and Address of Facilit Danzansky-Goldberg Memorial Chapel m01163 1170 Rockville Pike, Rockville, MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Two Years Immediate Cause (Final Lung Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner sician and burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician or use as the burial Physician/Medical law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the P.O. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1X Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform The certificate 1 ☐ Yes 2 X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🖰 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical соmpletely (Check only To the l within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie July 13, 2009 D23600 30. Name and address of person who completed Bruce R. Kressel 2141 cause of death (Item 23a) (Type Print) K Street NW #707 Washington DC 20037 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State parke 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day NATAN ROZOVSKI 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Bethesda der 1 Year | If Under 24 Hrs. Montgomery Suburban Hospital Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Min 1 ☑ M 2 ☐ F 609-62-0502 86 4/10/1923 Former USSR Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☑ Yes 2 ☐ No Gaithersburg 10f. Zip Code MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 101 Odendhal Ave. #814 20877 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 📉 No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electrical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ilya Rozovskiy Anna Maryampolskaya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Klara Rozovskaya - daughter 10101 Grosynor Pl., #618 Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/14/2009 Olney, MD Judean Mem. Grdns. 22. Name and Address of Facility Danzansky-Goldberg Memorial Chpl. 21. Signature of Funeral Solvice Licensee MO1477 1170 Rockville Pike Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PROSTATE ayro Die to (or as a consequence of) PANCYTOPENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examination to modify of

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Baltimore, Maryland 21215-0036

Box 68760,

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of Vital Records,

Division

Examiner sician and burial-transit Be Certification: To

executed been signed by the attending physician a should be detached for use as the burial certificate be this After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After after death.

Director: Af
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Physician/Medical \$ Completed

24a. Was an autopsy 2 No 1 TYes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

	referred to medical
examiner	
1 ☐ Yes	2No

27. Manner of Death 1 Natural 5 Pending

2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year) investigation

Hospital:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 🔁 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

D0033953

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 ROCKVILLE PIKE BETHESDA GLAINE

State Registrar

Medical

31. Date filed (Month, Day, Year) 14



15 inpatient 2 ER/Outpatient 3 DOA

28b. Time of

09-05402 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shawna Leigh Ridgell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 9, 2009 1855 hrs Medical Examiner Shana Leigh Ridge11 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hospital Center Prince George's If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Country)Maryland 2 X F 216-31-6663 1 M 18 01/08/1991 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 X No 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other trannatic event, the Medical Examiner must be notified at once injury or other trannatic event, the Medical Examiner must be notified at once Maryland St. Mary's Mechanicsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26385 Budds Creek Road 20659 <u>United States</u> Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces' 1 X Never Married 2 Married 2 X No Yes Widowed Yes, Give Year Yes 2 X No specify: Divorced Specify: White ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Student Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Edward Ridgell <u>Amy Leigh Bookwalter</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert E. Ridgell/Father 26385 Budds Creek Road, Mechanicsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Heart Cemetery 07/16/2009 Bushwood, Maryland Donation 5 Other Specify: Sacred 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical a. Multiple Injuries Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical #1 as noted per ME g896 10/7/09 TT g physician a the burial -UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the attending poor to use as the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ signed | Yes 2 No 3 Probably 4 🗸 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed? ✓ Yes 2 No 1 🗸 Yes certificate the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other; Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 V Yes 2 28a. Date of Injury Jul 9, 2009 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject driver of vehicle in vehicular accident 1 1705 hrs Natural Yes 2 V No Director: Pending 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) Point Lookout Rd @ Sunnyside Rd, Loveville, MD determined (Specify) Major Road / Highway To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

O_Q(

OCME 2006

State Registrar DHMH 17 Rev 1/2001 egistrar's Signature

Assistant Medical Examiner

m

Theodore M. King, Jr., MD.

31. Date filed (Month, F

Name and address of person who completed dause of death (Item 23a)

OCME

July 10, 2009

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Vear Month Day **Physician** Sean Richard Pratt Roberts Ju₁v 11. 2009 3:39 p /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16176 Murray Road Ridge St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 15€ M 2 ☐ F Director 02/25/1989 Maryland 20 <u> 220-37-5024</u> Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director St. Mary's Ridge Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or USA 20680 16176 Murray Road Funeral items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after * 1 Never Married 2 Married o. 1 ☐ Yes 2 No Specify þ Specify. White 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Roofer 12 h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kevin Roberts Margaret Susan Pratt ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trainonce. Margaret S. Pratt/Mother 16176 Murray Road, Ridge, MD 20680 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Charlotte Hall, MD Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 07/17/2009 22. Name and Address of Facility
Brinsfield Funeral Home, P.A.
22955 Hollywood Rd., Leonardtown, 21. Signature of Funeral Service Livenses KUG MD 20650 23a. Part 1. Enter the disease, or cor plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Exami sician and burial-tran Due to (or as a consequence of): Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Hinknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy perform 1 ☐ Yes 2 No 1 □Yes 2 NO 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \) Residence \(6 \) Other (Specify, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury 5 Pending investigation 1 Natural 3:39PM 109 ĺΝο 1 TYes 11 2 Accident heas 3 Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Pla / of Inury - At home, farm, street, factory, office buil ing, c. (Specify) 28f. Location City or To (Street and Number determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

24 hours a To the Hosp within 24 hor To the Fune completely fi

41680 Miss Bessie Drive, Leonardtown, MD 20650 C. Boyd M.D James Registrar's Signaty 31. Date filed onth, Day, Year) State 2009 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a manner stated.

29a, Certifier

29b. Signature and title of certifier

Medical

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated of the cause(s) and manner as stated of the cause(s) and manner as stated of the cause(s) and manner stated.

29d. Date signed (Montil, Day, Year) ζ

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JULY 13, Day 2009 Year 13:15 M Geraldine Rizer Alice 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CUMBERLAND ALLEGANY WMHS - MEMORIAL CAMPUS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Months Days 1 □ M 2 1 F 69 212-38-6365 10-12-1939 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 17√□Yes 2 □ No Bedford Hyndman 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15545 USA 115 Devon Way Apt 6 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Casserly Julius Martz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christina L. Merkel/ Daughter 318 Spring St., Fairhope PA 15538 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nation 3 Nation Removal from State 7-16-2009 | Hyndman, PA 4 ☐ Donation 5 ☐ Other (Specify) Hyndman Cemetery 22. Name and Address of Facility Harvey H. Zeigler Funeral 21. Signature of Funeral Service Licens Home Inc. 169 Clarence St Hyndman PA 15545 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) bleed Intra Crania Due to (or as a consequence of): Ceressal

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Marical Examinating must be notified along.

/Medical

10a. State

PA

Director

Funeral

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Completed

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Completed by Physician/Medical Examiner	If any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hyperlensing Due to (or as a consecutive of the pergy Ce	On quence of):				
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 ☐ Ectopi	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
ed by Ph	Part II. Other significant conditions con		sulting in the underlying	g cause given in Part I.			to the cause of death? Probably 4 Unknown
Complete	Hypophosohale	n [†] C			24a. Was an autopsy performe 1 □Yes 2	prior to death?	uttopsy findings available completion of cause of s 2 \(\sum \) No
Be (25. Was case referred to medical			26. Place of D	eath (Check only one)		
	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	ER/Outpatient 3 ☐	DOA Other: 4 Nursing	Home 5 ☐ Residen	ce 6 ☐ Other (Sp	ecify)
Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, street, fact	ory, office	28f. Location (Stre City or Town,		Rural Route Number,
Medical (29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and plation, in my opinion, death of	ace, and due to the cat courred at the time, dat	use(s) and manner e and place, and du	as stated. ue to the cause(s)
Me	29b. Signature and title of certifier	0		29c. License number	290	d. Date signed (Mor	nth, Day, Year)

DHMH 17 Rev 1/2001

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noss

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Madhusudhan Tarigopula MD

31. Date filed (Month, Day, Year) JUL 16 2009

D0066070

900 Seton Dr. Cumberland MD 21502

July 14, 2009

09-05663 Joshua Robinette Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 24157

		- For State	Cen	tificate of	Death		- 1		g. No.	2 Time of Death	
Physicia edical Exami	an/ ner	1. Decedent's Name (First, Middle,Last) Joshua	Edward		Robir			Date of Death Month July 19, 20	Day Year	3. Time of Death 1919 hrs	
		4a. Facility Name (if not institution, give Misty Valley Lane	street and number)	4	tb. City, Town, o Flintstone	r Location of			Allegany		
Funeral Director		5. Social Security Number 6. Sec 234-39-9761	7. Age (In yrs. la	ast birthday) Yrs	If Under 1 Ye Months Da		Min.	11/06		9. Birthplace (State or Foreign Maryland Country)	
d 10w any e		Usual Residence of Decedent		Town or Locati	ion Lintstor	ie				10d. Inside City Limits 1 Yes 2 X No	
he Maryland 1 or 28a-f show any ified at once	Director	10e. Street and Number 22304 Gilpin			10f. Zip Code	530		1	0g. Citizen of Wha	Α	
er death with the Maryland , or items 23a or 28a-f sho r must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 X No If Yes, Give Year	If Y	as Decedent of H 'es, specify Cuba Yes 2 X N	an, Mexican,	jin? (Spec Puerto Ri	cify Yes or No can, etc.)	14. Race - White,	American Indian, Black, etc. White	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiewith Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	or Dates:	16a. Deceder during m	nt's Usual Occup nost of working li	ation (Give I	kind of wor	rk done d)	16b. Kind of Bus		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours of Pleadth and Menda I Hygiene. ant: I firem 27 is marked other than "m	Be Com		Clay Robi	nette		Kel	li	I	Maiden Surname)	Warner	
MD 21 d 2 should Ith and Mer n 27 is man	70	19a. informant's Name/Relationship (T Kelli R. Warner)	/ Mother	22307		Road	, Fli		ne, MD 2	n, State, Zip Code) 21530 City or Town, State	
Baltimore, permit. Pages I am Department of Hea Important: If iter injury or other tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State	crematory or o	ther place) e Cemete	ry	07/2	24/2009	009 Flintstone, MD mmily Funeral Home, P.A		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Function: After this certificate has been signed by the attending physician and from the function in the fineral director, nase 2 should be deatched for use as the burial—transit	Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	AMENDED 23c. If yes, outcome of pre 1 Live birth 4 Pregnant at time of c	2 F	Fetal death Other (Specify)	3 Ectop	nic pregnar	ncy	23d. Date of Month	f delivery Day Year	
s, P.O. Box 687 ires that the death certific r signed by the attending it d be cleached for use as the	ed by Phy		9 OHKHOWH	resulting in the	e underlying cau	se given in F	Part I.		es 2 No 3	ribute to the cause of death? Probably 4 Unknown Were autopsy findings available	
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ion of Virtual Physicath. Our: After this the fineral dir	ਭ ⊢	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury Jul (Month, Day Year) Jul 19, 2009	28b. Time of 1818 hrs	,,	Injury at Wo	2 No. 1	Subject of vehicular	accident	errain vehicle involved ir	
Division pital or Attendi ours after death. leral Director: /	Certification:	2 Accident Investigat 3 Suicide 6 Could not determin	ot be 28e. Place of Injury - At ed (Specify) Dirt Trail					or Town Misty Valley	, State) / Lane, Flintston		
DIVIS To the Hospital or A within 24 hours after To the Funeral Dire	Medical C		cian: To the best of my knowledge: On the basis of examination and manner stated.	edge, death oc and/or investi	gation, in my opi	inion, death	occurred a	due to the ca at the time, da	ite and place, and	due to the cause(s)	
3	ž M	29b. Signature and title of certifier	The TAIL	2. A		.C.M.E.	er OC/\ 	/E	July 20, 2	ned (Month, Day, Year) 009	
nes		3. Name and address of person wh Theodore M. King, Jr., N		em 23a) I Examiner	111 Penr	Street, E	Baltimor	e, MD 212	201		
	State	31. Date filed (Month Day, Year)	32. Registrar's Sign	ature	1						

			1 - For State Registrar	State of	Marylan	•	artmen			and M	lental Hyg	giene Reg. No.	009	24158
	Dhysisi	an	1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medio		Patricia Morgan								July_	8,	2009	8:45 A ^M
14	Examir	er	4a. Facility Name (If not institution, given	re street and num	ber)		4b. City,	Town, or	Location o	of Death		4c. (County of Deat	h
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	Funeral			Sex 7 I□M 2Ď X F	. Age (In yrs.	V	If Under Months	Days	If Under:	Min.	8. Date of Birti (Month, Day	y, Year)	Co	hplace (State or Foreign untry)
	Director		034-16-3702 Usual Residence of Decedent			86 Trs.					July 7,	192	3 Mass	sachusetts
	land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Hary Hary	jo	Marvland Ken	+	C	hester	tour							1X Yes 2 □ No
	28a	rec	Maryland Ken 10e. Street and Number	<u>L</u>	0	nester	10f. Zip	Code				10g. Citiz	en of What Co	untry?
	3a ou	by Funeral Director	488 Heron Point						216	20			USA	
	ms 2	Jere	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.	Was Deced	tent of Hi	ispanic Orig	gin? (Sp	ecify Yes or No- Rican, etc.)	. 1	4. Race - Ame	
9	or Ite	F	1 ☐ Never Married 2 🔀 Married	Armed Ford	∑ No		1 ⊡Yes :		Specify:	i, Fuerto	nican, etc.)	i	Black, White	ə, etc.
ဋ္ဌ	within 72 hours after death with the Maryland ene. than 'natural', or items 23s or 28s-f show he Madical Exambher must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dat	es:		10 103	2,01140	Specify.				Specify:	White
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2	Hygie ther t	ပိ	17. Father's Name (First, Middle, Last	2		Hom	emake	r	18 Mothe	r's Name	(First, Middle,		wn Home	2
ä	ntal led o	Be									Urquhar		3377477	
2	hould d Me mark matic	ပ္	Walter S. Morga 19a. Informant's Name/Relationship			19b Maili	na Address	(Street :			al Route Numbe		Town State 2	Pin Code)
Maryland 21215-0036	d 2 s th an t7 is trau		Frank E. Rush/H			11					ertown,			
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any njury or other traumatic event, the Madical Examinat must be notified at ance.		21. Signature of Funeral Service Lice		i ne						ies, Inc		urk, b	z z u war c
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	Physician	6 4	Immediate Cause (Final	A Land	LRE	to th	10 11						ļ	Onset and Death
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П	Examiner		Compared to the second second	Mul-7	1-INF	ARCT	DE	ME	NTI	A				75 years
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9 ×	seath certific attending plant of the use as t	Physiclan/Med	IF FEMALE:	220 16 1100 0110										
Вох	attend attend for us	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Feta	al death 3	Ectopic pr					2	3d. Date of dea Month	ivery Day Year
P.0.	the 2	ysic	1 ☐ Yes 254No 9 ☐ Unknown	4 ☐ Pregna 9 ☐ Unknov	ntattime of o vn	ieath 5	Other (sp	юсту)						
	The law requires that the death certifica ate has been signed by the attending pt page 2 should be detached for use as it	Ph	Part II. Other significant conditions	contributing to dea	ath but not res	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	obacco us	e contribute to	the cause of death?
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a	n: Ti ficate or, pa		OF Management to medical									212 No	1 ☐ Yes	2)Q No
⋚	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 25 No	Hospital:	i 2 ⁻	I ED/Outs stray	200	Oth	26. Place er: 4 □ Nu		Check only o		CO15 (0	-61
ō	Phy ir this aral d	τ: To	27. Manner of Death	28a. Date of	Injury	28b. Time o		8c. Injury			28d. Describe h		Other (Spe	city)
on	Attending in death.	를	1 Statural 5 Pending 2 Accident investigation		, Day Year)	Injury	М	Worl	k? Yes 2 🔲	No				
Division of Vital	Atte	Ę	3 ☐ Suicide 6 ☐ Could not to determined	286. Place (of Injury - At h	ome, farm, st	reet, factory	, office	-				Number or Ru	ural Route Number,
Ö	s afte	Certification:	4 Li Homode	Daligin	g, etc. (<i>Speci</i> i	(9)					City or Tov	vii, State)		
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Cartifying P	hysician: To the t	est of my kno	owledge, deat	h occurred	at the tin	ne, date an	d place,	and due to the	cause(s)	and manner as	s stated.
	the Hin 24 the Fi	edical	one)	and manne	er stated.	ation and/or in	vestigation	,⊪nmyo	ріпіоп, сеа	tn occur	ed at the time,	date and	piace, and due	to the cause(s)
	To the to the total	Σ	29b. Signature and title of certifier	NINO	1 ₄		290	. Licens	e number	~ 0.4	7	29d. Date	signed (Mont	h, Day, Year)
			1 the 17	Vorte	_ /4	1	L	0	0415	> 8	/	1	-10-	09
	20		30. Name and address of person who	completed cause	of death (Iter	m 23a) (Type,	Print)	0.01	.0 1 .	and ham	7 I, MD		1620	
	~		itelen A Nobie				cn	254	erm		1, 1001	, =	1420	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature	,							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** E. Geraldine Redding 11:25p^M 2009 July 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Westminster Dove House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. Days Hours 1 □ M 2 ▼ F 217-03-1284 91 Director 7/20/1917 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, It a Madical Examiner must be notified at 1 Tyes 2 XNo Carroll Finksburg MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1446 Wesley Road 21048 USA by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: white 3 Noticed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sewing factory seamstress permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important; If item 27 is marked other than any injury or other transment. 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elvie Pearl Knight Carroll Wisner ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2806 Bauernwood Ave., Parkville, Md. 21234 John Redding, son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/12/2009 Hampstead, Md. Wesley Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 21074 934 S. Main Street, Hampstead, Md. Lemmer Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2.2 No 2 100 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specific 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

31. Date filed (Month, Day, Year) State Registrar

(Check o one)

and title of certifier

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1 0 2009

29b. Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ER

and manner stated.

3. Registrar's Signature

29d. Date signed (Month. Dav. Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 400 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5. Social Security Number Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours 1 ☐ M 2 🔀 F 1-14-1926 83 Director 219-22-6921 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No MD Baltimore Hampstead Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21074 4000 Beckleysville Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: white 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Medones. Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper lumber company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Milton Estes Addie Baugher မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John J. Reiser, Husband 4000 Beckleysville Rd., Hampstead, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation 7/8/09 Hampstead, Md. 4 ☐ Donation 5 ☐ Other (Specify) Eline Funeral Home M00741 934 Street, Hampstead, Md. 21074 denner Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): distress Syndrome. acute Respirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine neumowia Due to (or as a consequence of) Physician/Medical 0 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident

Examiner Division of Vital Records, P.O. Box 68760,

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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Hospital or Attending Physiclan: The law requires that the death certificate be executed ģ has this After 1 n 24 hours after death.

e Funeral Director: A

bletely filled in by the fu death. within 24

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State

Medical Doctor

and manner stated.

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

NPI 1104051945

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elizabuch K. Smelter

6 □ Could not be

determined

225 Greene St. Baltimore, MD 21201

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 🗌 Suicide

29a. Certifier

Medical

4 Homicide

32 Registrar's Signatur

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11, 2009 Year **Physician** July 1630 Charlotte W. Sweet /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Olney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/28/1950 6. Sex Birthplace (State or Foreign
Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min. Months 1 □ M 2 🔂 F 213-54-6708 58 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-4 shov any injury or other traumatic event, It is Medical Examiner must be notified. 1 ☐Yes 2 No Director MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 15616 Twin Valley Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. White Specify: ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Montgomery County Payroll Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Naomi Walter David D.Wallace 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Richard Sweet/Husband 15616 Twin Valley Court Silver Spring, Md 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 7/14/2009 Beltsville, Md 21. Signature PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory mest, shock, or heart failure. List only one cause on each lipe. Immediate Cause (Final Physician 784 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit Due to (or as a consequence of): attending physician Physician/Medical the ' IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 4 Pregnant 5 Other (specify) 2 No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred P Hospital or Attending P 24 hours after death. Funeral Director: After t After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

completely

Medical

Signature and title of certifier

31. Date filed (Month, Day, Year)

14

3altimore, Maryland 21215-0036

be executed

Division of Vital Records, P.O. Box 68760

29c. License number 100428

5/ Ver

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29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 10 /

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82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			// IVIC	ai yiailu	•			Death			Reg. N		11.9	24	162
п	Physicia		1. Decedent's Name	e (First, Middle, L Lvin Setz									Date of Do Month July		200 9	Year	3. Time of 12:07	p M
3	/Medic Examin		4a. Facility Name (# Holy Cros	f not institution, g ss Hospita		ımber)			4b. Cit		r Location of De er Spring			4		of Death	ery	
	Funeral Director		5. Social Security N 195–12–962		Sex 1 ½ M 2□ F	7. Age	e (In yrs. las	st birthday) Yrs.	If Und Month	er 1 Year s Days	If Under 24 I Hours N	Hrs. 8.	Date of Bi (Month, D t. 16	rth a <i>y, Yea</i> 19 2	6	9. Birth Cou	place <i>(State ontry)</i> Pennsy 1	or Foreign Vania
	land ow ■		Usual Residence of 10a. State	Decedent 10b. County			10c. City,	Town or Loc	cation								I 0d. Inside C	
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show rs Medical Evarrinar must be notified at	by Fui		ied 2 K Married 4 ☐ Divorced	Armed Fr 1 XX Yes If Yes, G Year or D	2□N ive	1944–4	1		2 X No		uerto Hic	an, etc.)		Specif	ck, White, ^{(y:} Wh:		
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212	l withir giene. r than	Completed by	Elementary/Seco	ndary (0-12)	College (1-4or 5	i+)			ntant	2)				Fina	ncial	Managem	ent
	ild be filed fental Hyg rked othe lic event,	To Be C	17. Father's Name William		st)						18. Mother's Cora I			e, Maide	en Surnar	ne)		
Maryland	nd 2 shou alth and N 27 is mai rr traumai		19a. Informant's N Thomasina								and Number of ven Parkw							
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninat must be notified at once.			position ☐ Cremation 3 5 ☐ Other (Spec		State		ce of Dispo netery, cren e of He			: 00	Date 11y 17 2009				•	own, State Maryla	and
Balti	permit. Departn Importa any inju		21. Signature of Fu	uneral Service Lic	ensee	٥.,		Fr 50	Name anci: O Un	and Addre s J. Co Lversi	ess of Facility Ollins Fu ty Blvd.	neral	l Home Silver	Inc.	int, M	1D 2090	01	
			23a. Part 1. En er t shock, or hea	he disease, or co	mplications that ly one cause on	caused each lir	the death.	Do not ent	er the m	ode of dyir	ng, such as car	rdiac or re	espiratory	arrest,			Approximat Interval Bet Onset and	tween
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- Appell	Examiner			1	Due to	(or as	a conseque	sequence 1): Encephalopathy										
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39 x	eath certificate be executed attending physician and for use as the burial-transit		IF FEMALE:		23c. If yes, ou	ıtcome	of pregnan	cv							224 D	ate of deliv	(OT)	
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a B	cate h	Com											per 1 □Yes	formed?	No	death? 1 ☐ Yes		
Vital	Physician: this certific ral director,	Be c	25. Was case refer examiner? 1 ☐ Yes 2 🔯	/	Hospital:	Innatio	ont 2 🗆 E	R/Outpatier	+ 3 🗆	DCA Oth	26. Place of ner: 4 \(\sum \) Nursir				6 D O+	hor (Case	(6.)	
ηof	ng Phy Iter this neral d	n: Tc	27. Manner of Dear		28a. Date (Mo			28b. Time of Injury		28c. Injui Wor	ry at		I. Describe				(iy)	
Division of	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To	2 Accident 3 Suicide 4 Homicide	investigat 6 Could not	be 28e. Plac	e of Init		ne. farm. str	M eet, fact	1 -	lYes 2 □No	28f.	Location City or To	(Street own, Sta	and Num	ber or Rui	ral Route Num	nber,
D	Hospital c 4 hours af Funeral D ely filled ir		29a. Certifier (Check only	1 Certifying 2 Medical Ex	Physician: To the	basis o	of examination	ledge, deat	n occurr vestigat	ed at the ti	ime, date and popinion, death	olace, and	d due to th	e cause	e(s) and n	nanner as	stated.	s)
	o the lithin 2, o the F	Medical	one) 29b. Signature and	title of certifie	and ma	nner sta	ated.			29c. Licens				29d. [Date sign	ed (Month	, Day, Year)	
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	23		30. Name and add				leath (Item	23a) (Type,		lver S	pring, M	D 209	10	*******	-			
Ş.	Sta	ite	31. Date filed (Mor				ar's Signati		4 4							· · · · · · · · · · · · · · · · · · ·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State		State of Ma	ıryland		rtment of F tificate of		id Men		iene eg. No.)	000	21.163
		Registrar 1. Decedent's Name	(First, Middle, Las	<i>it)</i>			inouto or .			Date of Deat	th	V	3. Time of Death
Physici /Medic		Ida K. Sc	hneider							Month .1y 10	Day 200	Year 9	4:30 P M
Examir	20	4a. Facility Name (If r					4b. City, Town, o	Location of D	Death			unty of Death	
W. C. A. A. MARINE		Rockville 5. Social Security Nur			e (In yrs. las	st hirthday)	Rockvill If Under 1 Year	e If Under 24	Hrs. 8. [Date of Birth		tgomer	y place (State or Foreign
Funeral Director		579-18-67		_ V.	2	Yrs.	Months Days		11 ⁽	/16/19	$916^{(\text{Pea}r)}$	Cou	ntry) ecticut
5 25		Usual Residence of D			10o City	Town or Loc	cation						10d. Inside City Limits
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the N 28a-1 notifi	rect	10e. Street and Numl		. L y	Roci	CVIIIC	10f. Zip Code			1	0g. Citizen	of What Cou	intry?
h with 23a or st be	al Di	14200 Woo	dcrest D	rive			20853				USA		
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should should nd Me mark mark	은	19a. Informant's Nar		Type. Print)		19b. Mailir	ng Address (Street				r, City or To	own, State, Z	ip Code)
ING 2 sl alth and 27 is r		Susan Bra	indstadte	r-Daughter	:	14200	Woodcre	st Dri	ve R	ockvi	lle, 1	4D 208	53
Dallillore, bermit. Pages 1 ar Department of Her mportant; if item nny injury or othe				Removal from State	cei	metery, crer ≥an Me	sition (Name of matory or other pla emorial G	dns. 7	Date /12/2	009	Olney	ion - City or 1	land
permit. Departm Departm Importa any inju		21. Signature of Fun	neral Service Licer	nsee		In	2. Name and Address 1091 Rock	ss of Facility] Rockv: ville,	Edwar ille MD 2	d Sago Pike 0852	el Fu	neral :	Direction,
Physician		Immediate Cause (F	inal	plications that caused one cause on each lin		Do not ent	er the mode of dyi	ng, such as ca	ardiac or re	espiratory are	rest,		Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	-	Due to (or as			с різсаз						
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execu execu in and ial-tra	Examiner	that initiated events resulting in death) La		C Due to (or as	a conseque	ence of):							
ficate be executed physician and is the burial-transit	dical			Respira	tory	Failu	re						
box sath certi	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 9 □ Unknown	months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	□Ectopic pregnanc □ Other (specify) _	y			230	I. Date of deli Month	very Day Year
that led b	ò	Part II. Other signification Dementia		contributing to death be	ut not resul	ting in the u	nderlying cause gi	ven in Part I.				contribute to	the cause of death?
he lar e has	Completed									24a. Was autop perfo 1□ Yes	rmed?	24b. Were au prior to death? 1 □ Yes	topsy findings available completion of cause of
- 10 11	Be C	25. Was case referre	ed to medical					26. Place o	of Death C	heck onl o			
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tending P death. stor: After i	ion:	27. Manner of Death 1₹ Natural	n 5 ☐ Pending investigatio	28a. Date of Inju (Month, Day		28b. Time o Injury	Wo	ryat rk?]Yes 2∐No		I. Describe h	iow injury c	ccurrea	
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	e lago Place of inju	ury - At hor c. (Specify	me, farm, sti	reet, factory, office			Location (S City or Tox		Number or Ru	ıral Route Number,
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10		1	vomm	0. 0080	14		D473	3U 			July	11, 20	JU 9
V		30. Name and addre		completed cause of d			Print) Drive,	Suite '	207	Rocks	111 ₀	MD 201	852
S S	ate	31. Date filed (Mont	th, Day, Year)	32. Registr	ar's Signat	ure _		DUILE A		MOCKV.	rtte,	200 ست	
Regis		JUI	L 14 200	19 Dentin	1.	bar	Ked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Marie Sepety 5:00 p Felicia 8, 2009 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Waldorf 1503 Nicholas Road 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Months 1 □ M 21€ F 07/24/1969 Maryland Director 218-90-8391 39 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be realfied at 1 ☐ Yes 2X No Director Waldorf Charles Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with in ment of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or: USA 20601 1503 Nicholas Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1√2Yes 2□No Specify: Unknown Specify. ₫ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronic Wholesale Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Coleman Sonia Guillermo Morales ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1503 Nicholas Road, Waldorf, MD 20601 Michael S. Sepety/Spouse permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/14/2009 Trinity Memorial Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** cardiopulmonari /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): burial-tran Due to attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 No No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. funeral director, After 24 hours after death. Pruneral Director: A filled in by

Maryland 21215-0036

altimore,

Be Certification: To

Medical

State Registrar

completely

within 2

2

4 Homicide 29a. Certifier (Check only

examiner?

27. Manner of Deat

1 Natural

2 Accident

3 Suicide

6 ☐ Could not be

5 Pending investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 \(\text{Nursing Home} \) 5 \(\overline{\overline{N}} \) Residence \(6 \) Other (Specify)

28d. Describe how injury occurred

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 07/09/2009 D60181

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Stacie Gump, M.D. 31. Date 4 2009

Waldorf, MD 20602 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009^{ear} JULY 13, 17:13 M Mary Jane Schade 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ALLEGANY WMHS - MEMORIAL CAMPUS CUMBERLAND Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🖫 F 219-34-7106 71 03/25/1938 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No Cumberland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 1532 B E. Oldtown Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant State Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Galford Bittinger William Robert Evelyn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12207 Little Valley Dr, NE, Cumberland, MD Barbara Hemmis/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Cumberland Crematory 07/18/2009

or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Physician /Medical

Physician

/Medical

Examiner

10a. State

MD

12

4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service

Funeral

Director

28a-f show

Director

by Funeral

Completed

Be

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ir than "natural", or items 23a or 28a-f shot the Medical Examination to ust be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Modrol Examination.

Baltimore, Maryland 21215-0036

with the Maryland

death v

Examiner

23a. Part 1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes ✓ No Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 WNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 1 Yes 2 √No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Lath 28b. Time of 28c. Injury at Work? 28d. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No **∠** Accident 6 ☐ Could not be ″3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a Medical and manner stated.

or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-trar sate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760. director, in by the funeral 24 hours a Hospital

5 ☐ Re	sidence	6 Other (Specify)	
Describe	e how inju	ary occurred	
Location City or To	(Street a own, Star	and Number or Rural Route Number, te)	
		(s) and manner as stated. and place, and due to the cause(s)	
	29d. D	ate signed (Month, Day, Year)	
	40	7/14/09.	

1 □Yes

Cumberland, MD

23d. Date of delivery

Day

3 Probably 4 Unknown

Were autopsy findings available prior to completion of cause of death?

2**(**[2]No

Month

21502

ewda

ew dai

Onset and Death

22. Name and Address of Facility Adams Family Funeral Home, P.A.

404 Decatur Street, Cumberland, MD

State Registrar

To the I within 2

31. Date filed (Month, Day, Year) JUL 15 2009

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAKIL, HUMA, M.D., 625 KENT AVENUE, SUITE 301, CUMBERLAND, MD 21502 32. Registrar's Signature

29c. License number

D46346

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 2009 Lamon 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 5185 Meadows Farm Road Lothian If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Social Security Number 6 Sex Months 1 X M 2 □ F Yrs. 03-19-1952 Wash., D.C. 220-62-9263 57 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 🕅 No Lothian Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20711 USA 5185 Meadows Farm Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1972-74 1 ☐ Never Married 2 X Married Specify: white 1 ☐ Yes 2 📉 No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) building contractor construction 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Irene Perrie Kaymond Matthew Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5185 Meadows Farm Road, Lothian, MD Karen A. Smith, wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens 07-17-2009 Dunkirk, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses Willian 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 years disease or condition resulting in death) Una Lanc Due to (or as a co. quence of): Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery

Physician /Medical Examiner

physician and the burial-transit

as been signed by the attending | 2 should be detached for use as

has

After

within 24 hours a

To the Funeral I

completely filled

2

after death neral Director: /

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director

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

of Health of item 27 is

item 27

Department o Important: If any Injury or once. <u>=</u> ŏ

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

9

Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventher must be millied at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last

Physician/Medical Completed by

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 5 Other (specify)

3 Ectopic pregnancy

Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 1 ☐Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

5 Pending investigation 6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

900

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Svite 300 Annipolis

26. Place of Death (Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

32. Registra s Signature

and manner stated.

Besta

State Registrar

3+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 Ricky Lee Stickler Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 17,1957 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours **X** M 2□ F 52 June Pennsylvania 219-66-1918 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location. 10a State 10b. County s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinant in the Indiffer at 1 ☐ Yes 2 ☐ No Hagerstown Director Washington Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 1 Hygiene. 21742 U.S.A 13438 Clopper Rd. Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Ş 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security 5 Mote1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Miller Ralph Stickler ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sandra D. Stickler (Wife) 13438 Clopper Rd. Hagerstown, Md. 21742 permit. Pages 1 a
Department of Hee
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2009 Smithsburg, Md. July 16, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Pert : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (r as a consequence of): 3 weeks disease or condition resulting in death) /Medical **Examiner** 34-lars ence Failur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or AttendIng Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 No 1 ☐Yes 2 No the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

P.O. Box 68760, Division of Vital Records, within 24 hours To the Funeral completely

3H-2 State

Registrar

31. Date filed (Month, Day, Cear)

29b. Signature and title of certifier

JUL 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistra s Signature

368 nul

368 miles.

29c. License number

29d. Date signed (Month, Day, Year)

Sheel-Heigestern MD 2/1740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	100	back) _		
7	10 /1		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, F	Print)	/	Com	brid	- 0	MD	,
	To t Com	Ž	29b. Signature and title of certifier	ion or	/		29c. Licens	e numbe	99-	73	29d. [and place, and due to Date signed (Month, 7/13/09) MD	Day, Year)
	he Hospi in 24 hou he Funer pletely fill	Medical		hysician: To the best of miner: On the basis of and manner sta									
Division	To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined	pe 28e. Place of Inju building, etc	ury - At home, fari c. (Specify)	m, stre	M 1 □	Yes 2		City or To	own, Sta		
of \	ding Physie h. After this c funeral dire	ဥ	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie		<u>. </u>	t 3 □ DOA Oth 28c. Injur Wor	4 💌		me 5 Res 28d. Describe		6 ☐ Other (Speci jury occurred	ify)
Vita	sician: The certificate h rector, page	Be	25. Was case referred to medical examiner?	Hospital:			10			(Check only	one)		
of Vital Records,	The law cate has page 2 s	Completed								24a. Was auto perf 1 □Yes	opsy formed?	prior to co death?	opsy findings available ompletion of cause of 2 \(\square\$ No
cord	w require been sign should b	eted	Dementia,	urinary	reten	770	(7)			73.00%		45	bably 4 Unknown
S, P	res that t signed by be detac	by Ph	Part II. Other significant conditions			•		en in Pa	rt I.			o use contribute to t	
O. Box (at the death certifi by the attending tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a: 9 Unknown	2 Fetal death		Ectopic pregnand Other (specify)	:y				23d. Date of deliv Month	very Day Year
68760,	ificate be executed g physician and is the burial-transit	edical	that initiated events resulting in death) Last	Due to (or as	a consequence o	of):							
	cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	Due to (or as	a consequence o	of):							
	/Medical Examiner		•	Due to (or as	a consequence o	of):							
	Physician (Modical		snock, or neart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. urose	psis								Onset and Death
	20 E 29		23a. Part1. Enter the disease, or comshock, or heart failure. List only	nplications that caused	the death. Do n	17	00 Locus	t st	reet (Cambrid	dge,	Maryland	Approximate Interval Between
Baltimore,	permit. Pa Departmer Important any Injury once.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		Salis		y Cremato Name and Addre homas Fu			/2009	<u> </u>	lisbury,	Maryranu
Jore	ages 1 ant of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State			sition (Name of latory or other place			Date /2000		Location - City or To	
	nd 2 sh alth and 27 is rr er traum		19a. Informant's Name/Relationship Eleanor L. Hanl:									y or Town, State, Zij e, Marylar	
ylan	ould be I Mental Iarked o	To B	Walter B. Hanlin						elma	Iamon			
d 21	filed wi I Hygier other th ent, th	Be Cor	9 17. Father's Name (First, Middle, Last	*)			Carpen		ther's Name	(First, Middle	e, Maide	Construc	tion
215-	thin 72 l ne. nan "nat	nplete	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5		(Give k life. D	ent's Usual Occup kind of work done OO NOT use retired	during m d)	ost of worki	ing	160.	Kind of Business/In	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the World Event or the permittion of the other traumatic event, the World Event or the permittifued at once.	Completed by Funeral Director	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced		Korea		□Yes 2√√ No	Speci	fy:		1 406		White
B	tems 23	unera	11. Marital Status	12. Was Decedent I		13. V	Vas Decedent of H Yes, specify Cuba		Origin? (Spo	ecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White,	can Indian, etc.
8	with the	Dire	10e. Street and Number 107 Buena Vista ?	\venue	-		10f. Zip Code 21 6	513			10g. (Citizen of What Cou	,
\bigcirc	e Maryland Ba-f show	ctor	Maryland Dorche	ester	Ca	ambi	ridge						1 □Yes 2X No
	fand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loc	eation						10d. Inside City Limits
	Funeral Director		726-18-9280	1 X MA 2□ E		rrs.	Months Days	Hour		8. Date of Bi (Month, D Oct 17	ay, Yea 19	28 West	ontry). Virginia
			Chesapeake Woods 5. Social Security Number 6.		e (In yrs. last birtl	hdayli	Cambrio	_	er 24 Hrs.	8 Date of Ri	irth	Dorches	ter place (State or Foreign
· Marie	/Medic	cal	Robert Lee Ha 4a. Facility Name (If not institution, gir				4b. City, Town, o	r Locatio	n of Death	July	11,	c. County of Death	11:15 P M
	Physici	an	1. Decedent's Name (First, Middle, La			-				2. Date of De Month		2009 Year	3. Time of Death
			For State Registrar	State of Ma	-	•	rtment of F tificate of			ieniai ny	Reg. N	(w w w	24100

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28, 2009 4c. county of Death 00pM JUNE /Medical Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4h. City Examiner Street Apt. 213 If Under 24 Hrs. Hours Min Dorchester 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Sex 102 M 2□F Days Year) Months 218-20-8878 192 Director Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show notified at 1 √es 2 No Dorchester Director bridge filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or Examiner must be treet by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ID Yes 2 No 1950
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No 'natural", or 3 ☐ Widowed 4 ☐ Divorced Black Completed and Mental Hygiene.
is marked other than "natur aumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Advisor Auto Dealersh' 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be e e +nna ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a dge, MD. 2/613 Marion for 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 15/09 Hurlock, MD 4 □ Donation 5 □ Other (Specify) Cemetery Veterans 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Cambridge, MD. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final Physician LUNG CAN Supe disease or condition resulting in death) NOT /Medical Due to (or as a consequence of): DISCOUTIVED Examiner Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-trar Due to (or as a consequence of) Suche ter Records, P.O. Box 68760, physician Completed by Physician/Medical as the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MKSS 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate GUNCOSE NTO 1 Yes 2 No or Vital Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or (Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of fertifier 29d. Date signed (Month, Day, Year) MD 00693 2009 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRITARE MUNTBE USAN 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Doris N. 2. Date of Death Shorter Day **Physician** 11, 2009 July 12:14 🖔 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 1702 E. Gate Drive Salisbury Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F 220-20-9164 82 Maryland 06/03/1927 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, it is Medical Examinar must be indiffed at 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1X Yes 2 No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA 1702 E. Gate Dr., Apt. 501 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by white 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland unit secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Ewing Benjamin S. Coates ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Mill Pond Lane, Salisbury, MD 21804 Kathleen McIntyre/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 7/14/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Holloway Funeral Home Professional Assessol Snow Hill Rd., Salisbury, MD 21804 Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conuence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se's conesquence of) Examiner The law requires that the death certificate be executed ied by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No P.0. 9 Unknown 9 Unknown been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, þ 3 Probably 4 Unknown icate has been sig ; page 2 should b 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes Division of Vital Physician: After this certific funeral director, 25. Was case referred to edical examiner? 26. Place of Death (Check only Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 No ၉ 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office uilding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certify ng Physician
2 Medical Examiner: 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number

State Registrar Mitchell

31. Date filed (Mon

31413 Winterplace PKWY

SALISBUYY. MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kar

10.01

Registrar's Signa

146

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 13, 2009 5:30 a. Ju1y Marie Alice Taylor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Great Mills 21724 Garfield Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Min. Hours Months Days 1 □ M 2 🗓 F 07/27/1918 220-16-7245 90 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Myclical Examination in the rediffical at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2X No Director Maryland St. Mary's Ridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20680 USA 48390 Wynne Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXXVo Specify: Specify. White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Government Court Commissioner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cullison Sara R. Lewis Herbert ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other the 000c. 48485 Wynne Road, Ridge, Maryland 20680 Sally Scheible/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 KX remation 3 ☐ Removal from State Charlotte Hall, MD Brinsfield-Echols :07/15/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Brinsfield Funeral Home, P.A.
22955 Hollywood Rd., Leonardtown, of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052 MD20650 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. ling, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): Due to (or **Examiner** www Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Examine physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 PNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☐No 24a. Was an autopsy performed? 1 Yes 2 No this certificate has al director, page 2: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: $_{4\,\square\,\,\text{Nursing Home}}$ 5 \square Residence 6 $\square\,\,$ Other (Specify) Caregiver Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After the 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier t 🗐 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ss of person who complete ause of death (Item 23a (Type, Print) 30. Name and and 24035 Three Notch Rd., Hollywood, MD 20636 P. Jarboe, M.D. James 31. Date filed (Month, egistrar's Signatur Day, Year) State 17

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 5:15 p M 11 Gilbert E. Twaddell July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil 124 Maryland Dr. Earleville Birthplace (State or Foreign Country) f Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Yrs DE 177-30-7446 72 October 30, 1936 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Cecil MD Earleville 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 **USA** 21919 124 Maryland Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No /959

If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Harry G. Twaddell Myrtle E. Hanby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 124 Maryland Dr.., Earleville, MD 21919 Gail E. Twaddell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 16, 2009 West Chester, PA R.A. Ferris & Co., Inc. hal Selvice Licensee 22. Name and Address of Facility 21. Signature of For Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eachyline. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequer ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No fоr 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? tate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1□ Yes 2 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 250 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 1 ☐ Yes After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Phospital or Attending P 24 hours after death. Funeral Director: After t Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1/ Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date sidned (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

ame and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 200 Alberta B. Tompkins JUly /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctors Community Hospital Lanham Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F 87 218-24-6492 October 27, 1921 Quantico, MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertal Hygiens. Internating them 23a or 28a-1 show Important: If item 7 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, It is Insaliced Examination in the protection of the continual ministrum or the continual in the contin 1 X Yes 2 No Director Maryland | Prince George's Greenbelt 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20770 4-C Hillside Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. Specify: White ð 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Woolford Bounds Roland James Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8511 Magnolia Drive, Lanham, MD 20706 Martha T. Folk / Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 8/5/2009 Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Ligenses 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 enis Memen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Jany yrs provas Physician disease or condition resulting in death) /Medical (of as a consequence of) Examiner rial Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical - nse IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Esophage Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D31001 MD completed cause of death (Item 23a) (Type, Print) 7500 Green way Cn Yr. Dr. #430 30. Name and address of person v Greenbelt, MD 20770 kewitz.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 8 Irvin Bradley Taylor 2009 0350 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Rehabilitation + Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Wicomico Salisbur If Under 1 Year Year If Under Days Hours Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1**X** M 2□ F 52 212-72-1743 1-18-1957 Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County items 23a or 28a-f show ner must be notified at 1 Xes 2 No Director New Church Accomack VA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 23415 Completed by Funeral 7098 Pearl Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status r than "natural", or iten 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify Specify Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other this any injury or other traumatic event, I'm once. 10th Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosie Lee Cropper ဂ William Houston Taylor 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy Taylor/Brother PO Box 11, Horntown, VA 23395 20c. Location - City or Town, State Dover, DE. 20a. Method of Disposition 2010 Place of Pisposition (Name job n LLC Tabernacle Bapt 7/18/2009 Horntown, Cemetery
Name and Address of Facility
Bennie Smith 917 W. Isabella St
Salisbury, MD 2180 21. Signature of Funeral Service Licensee Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each the Immediate Cause (Final disease or condition resulting in death) **Physician** Ray /Medical Due to (or as a consequence of): Examiner horac can Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Directo for as a consequence on Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Ho Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1 and 2 should be filed within 72 hours after death with the I Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

State Registrar 29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

William H. Robins.

JUL 13 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 200 C

Registrar's Signature

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ave.

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	Cer	tificate of l	Death		Reg. No	2009	24175
	Physicia	an	1. Decedent's Name (First, Middle, Last) MARJORIE VIRGINIA THOMP	SON			2. Date of De Month		2009 Year	3. Time of Death 11:15P M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) 116 OUAILWOOD PARKWAY	SON		r Location of Death	2011	40	County of Death	11.13F
	Funeral Director			rs. last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date of Bir DEC • 3	rth	9. Birthi	place (State or Foreign of try) H., D.C.
Marvland	a-f show	ctor	Usual Residence of Decedent	City, Town or Loc	ation NEWBUR	G			1	0d. Inside City Limits 1 ☐ Yes 2 🌠 No
edt the	23a or 28 st be not	Funeral Director	10e. Street and Number 13465 ROCK POINT ROAD		10f. Zip Code 206	64			itizen of What Coul	ntry?
ind 21215-0036 he filed within 72 hours after death with the Maryland	perference ragges i and a Should be fined within 7.2 blodds and beauth with the meal year, perference ready perfect the state and Mental Highene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Married 2 □ Married 3 ☆ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba □Yes ※ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	D-	14. Race - Americ Black, White, Specify: WHI	etc.
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Iryla Proupp	marke marke	မ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailine	a Address (Street	ATLDA L			RIEDRIC or Town, State, Ziu	
, Na	alth ar		WILLIAM R.JACKSON, SRNEP	HEW 116	5 QUAIL	WOOD PKY			•	
Baltimore, Maryland	ment of He ant: If item ury or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		sition (Name of latory or other place OLN CEM	i -		BRE	ocation - City or To	
Balt	Departi Imports any Inj		21. Signature of Funeral Service Licensee M00479	22. R.Z. L.Z.	Name and Addre AYMOND A PLATA	ss of Facility FUNERAL , MD. 206	SERVI	CE,	P.A.	
.) i	hysician and hysician and as the prival-transit	al Examiner	23a. Part 1. Enter the disease, or complication that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a considered) Due to (or as a considered)	equence of):	C C	ig, such as cardiac	or respiratory a	arest,		Approximate Interval Between Onset and Death
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Divis	rs after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spe	t home, farm, stre ecify)	eet, factory, office		28f. Location City or To		and Number or Rui te)	al Route Number,
na Hospi	within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) CertifyIng Physician: To the best of my leading to the basis of examiner: On the basis of examiner and manner stated.							
_ P	Voit To t	M	29b. Signature and title of certifler		29c. Licens	se number		29d. D	eate signed (Month)	Day, Year)
			30. Name and address of person who completed cause of death (II	tem 23a) (Type, F	Print)	ole for	~	\\ \lambda	100	- J
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sig	gnature	1.00	G 10	/	-)	5-0	176

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09-05375 Edv

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	13109 E		ll Roa	.d			2090	6				JSA		
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Baltimore, permit. Pages I an Department of Hea Important: If iter		21. Sign dure of Fur	neral Service lice	inse		ļi	HILI	P D.	RINA	ALDI	FUNE i 2 5v	ERAL lver	SERV	ICE,P.	A. 20910
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Division tal or Attendis us after death al Director:	icat	2 Accident 3 Suicide	Investig	28e. Pla	ace of Injury	- At home, farr	n, street, fa	ctory, offic	e building,	etc.	OF TOU	m State)		or Rural Route	Number, City
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate by Thours after death The hours after death or this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the best filled in by the funeral director, page 2 should be detached for use as the best properties.	Certification:	3 Suicide 4 ✔ Homicide	determ	ined (Specif	y) Local						13100 Ma				
Division To the Hospital or Attendum within 24 hours after death or on the Funeral Director. Completely filled in by the fil				sician: To the b	est of my kn	owledge, death	n occurred a	at the time, in my opin	date and ion, death	place, and occurred a	I due to the o at the time, o	cause(s) and late and pla	o manner a ice, and due	s stated. e to the cause(s	;)
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:40 a Vincent July 9, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring 3909 Littleton Street 8. Date of Birth (Month, Day, Sept. 1, 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1975 Months Days Hours Min 1 ☐ M 2 KF 219-17-4162 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Asolical Expr. 17to 1. stat by 10 dillied at Silver Spring 1 ☐ Yes 2 No Montgomery Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20906 3909 Littleton Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Human Resources College (1-4or 5+) 5+ Elementary/Secondary (0-12) Outsource Firm Pension Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Jubuisson Jean Herbert Vincent ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3909 Littleton Street, Silver Spring, MD 20906 Margaret Vincent/Mother if item 27 is Department of Health Important: If Item 27 any Injury or other tr Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 18 2009 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Signature of Funeral Service Licenses 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metastatic Breast Cancer few years Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1∐Yes 2**X**No 9 Unknown 9 Unknown cate has been signed I page 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes 2 No 1 ☐ Yes after death.

Director: After this certific 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ∐Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death

Division of Vital Records, within 24
To the Fun
mpletely file

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

29a, Certifier

1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D38262 29d. Date signed (Month, Day, Year)

July 10, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type Print)
A. Menchiratta, MD 2401 Research Blvd. #330, Rockville, MD 20850

State Registrar

filled e Funeral



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24178 State of Maryland / Department of Health and Mental Hygiene | | |

			1 - State Registrar			Cer	tificate of	Death			Reg. No.	_ 0 0 0	Email	
	Physicia /Medic		1. Decedent's Name (First, Middl		2. Date of D Month				Death 3. Time of Death					
			Ruth Elnora								10, 2009 6:16 P			
	Examin		4a. Facility Name (If not institution	n, give street and number)			4b. City, Town, or Location of Death					County of Death		
			New Hope Ass					erla				Allegar	ly.	
П	Funeral		5. Social Security Number 215–26–6921	6. Sex 7. Ag	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da	rth ay, Year)	Col	pplace (State or Foreign untry)	
	Director		Usual Residence of Decedent		79	115.				03/24/	/24/1930 South Carolina			
	and and		10a. State 10b. County	-	10c. City, To	own or Lo	cation						10d. Inside City Limits	
	/aryl	Director	MD Alle	Allegany Cumberland									1 ☐ Yes 2 🔀 No	
	the 1		10e. Street and Number				10f. Zip Code				10g. Citizen of What Country?			
	should be filed within 72 hours after death with the Maryland and Menal Hygiene. Marked other than "natural" or items 23a or 28a-f show marked other than "natural" or items 23a or 28a-f show matic event, the "sedical Examinar must be notified at		10827 Mexico Farms Road, SE				21502				USA			
		Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13.	Vas Decedent of F f Yes, specify Cub	lispanic Or	igin? (Spec	cify Yes or No	D-	14. Race - Amer		
٥	or ite		1 ☐ Never Married 2 ☐ Mar	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes Give			1 □Yes 2 ☑ No Specify:			ican, etc.)		Black, White	, etc.	
2	ours iraf",	d by	3 X Widowed 4 ☐ Divorced	3 X Widowed 4 ☐ Divorced Year or Dates:			THE PARTY			Specify: White				
ה	72 h 'natu	ete	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Ki 	o. Kind of Business/Industry		
9200-91212	filed within 72 Hygiene. sther than "na sther the Medic	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			Homemaker						Home		
	Hygie Hygie Iher	ပိ	17. Father's Name (First, Middle,	Last)			Homemak		er's Name	(First, Middle	. Maiden			
yland	d be dental	To Be	John	William	Henr	У	Layne	_	nie		ement		ampton	
\leq	should nd Me mark imati		19a. Informant's Name/Relations				g Address (Street	and Numb	er or Rural	Route Numb	er. City o	or Town, State, Z	ip Code)	
Mar	nd 2 suith an 27 is rrau		Bonnie S. Harp				Blake Te							
ē,	s 1 au of Hea item othe		20a. Method of Disposition		20b. Plac		sition (Name of natory or other pla		Da			ocation - City or	Town, State	
Ë	Page nent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				m @ Rock		07/1	4/200) F1	Lintston	e, MD	
altimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service										Home, P.A.	
מ	8 3 3 6 8		Klue	1 adam	5		404 Deca	tur S	Street	c, Cumb	perla	and, MD	21502	
			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that caused only one cause on each li	d the death. (Do not ent	er the mode of dyi	ng, such as	cardiac or	respiratory a	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			enti-	- card	1054	dan	dise	·N		Onset and Death	
	/Medical		resulting in death)	Due to (or as									1	
	Examiner	Examiner	Sequentially list conditions b.											
	ed sit		Sequentially list conditions, if any reading to the cluster cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	consequence of):								
	w requires that the death certificate be executed to be executed to been signed by the attending physician and should be detached for use as the burial-transit	хап	that initiated events resulting in death) Last	a consequen	onsequence of):									
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68/6 0,	ficate phys the	n/Medical		d										
×	n certi		IF FEMALE: 23b. Was decedent pregnant		3c. If yes, outcome of pregnancy							23d. Date of delivery		
20	death e atte d for	hysician	in the past 12 months? 1									Month Day Year		
5	t the by the ache	hys	9 Unknown											
'n	s tha gned e det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							tobacco ι	bacco use contribute to the cause of death?			
ğ	quire en sig uld b								1 🗆	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkr				
Hecord		plet								24a. Was		24b. Were au	topsy findings available completion of cause of	
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DIVISION OF	ng P	ü	27. Manner of Death 1 Natural 5 □ Pendir	b. Time of Injury	of 28c. Injury at Work? 28d. Describe				how injury occurred					
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	cati	2 Accident investigation				M 1 □Yes 2 □No							
<u> </u>		Certification:	4 Homicide determ	nined 20e. Place of Inj	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
_		Medical Ce	29a. Certifier 1 \(\mathbb{Z}\) CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	24 h		(Check only one)											
	Fo the within Fo the compl		29b. Signature and title of certifie	29c. License number 29d				29d. Da	d. Date signed (Month, Day, Year)					
) ()		D36766 J				Ju:	July 11, 2009				
,	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
	nds													
	Sta		31. Date filed (Manth, Day 3ar)	2009 Sent a	rar's Signature	la.	4.1							
	Registr	ar	001 - 07	Lous penga	1 13.	ger acce	La Carte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of	Maryland / [rtment of F <i>tificate of i</i>			giene Reg. No. 0	09	24179		
		Decedent's Name (First, Middle, Last)					2. Date of				3. Time of Death		
Physic		Jean Sprain Wilson						Month July					
/Med Exami		4a. Facility Name (If not institution	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death			
d Exami		Suburban Hospital				Bethesda			Montgomery				
Funera		5. Social Security Number	6. Sex 7.	. Age (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da)	h v, Yea <i>r)</i>	9. Birthp Cour	lace (State or Foreign try)		
Directo	r	278-12-3431	1 □ M 2 🔀 F	86	Yrs.			Feb. 6	,1923	Ohi			
pu v		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation				1	0d. Inside City Limits		
laryla sho	ō	,	a am a Kit	,		ockville					1 ☐ Yes 2 🙀 No		
the N	rect	MD Montgomery 10e. Street and Number			100	10f. Zip Code		10g. Citizen o	of What Cour	try?			
with Sa or	Ö	6111 Montrose Road #625				208		Unite	d Sta	tes			
(I Z I Z I 3-UU30 filed within 72 hours after death with the Maryland Hygiene. Hyber than "natural", or items 23a or 28a-f show ent, Ita 11 of 25a Everting neatte actificat	Funeral Director	11. Marital Status	12. Was Decede		13.		as Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.			No- 14. Race - American Indian,			
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rylis hould d Me mark matic	은	•				na Address (Street	and Number or Ru			vn, State, Zij	Code)		
Mand 19 sell the art 19 sell t		Hoke Wilson /				_	gton Plac						
f Hea		20a. Method of Disposition		20b. Place o	of Dispo	sition (Name of matory or other pla	-	Date		on - City or To			
DESIGNATION FOR MISTING ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Modral Evention must be notified at		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				tan ematory	July 2009	16	Alavar	ndria	Virginia		
mit. F sartm oortan		21. Signature of Funeral Service			22	Name and Addre	ess of Facility				_		
Dermi Depar Impor		TRACYA. In	WER Moi	(17	D	eVol Fune	eral Home Gaither	sburg, N	D 208	r Park 77	Drive,		
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OT VITA Physician: this certific	9 8	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ In	patient 2. ■ER/O	utpatie	nt 3 □ DOA Ott	her: 4 🗆 Nursing l	Home 5 ☐ Resi	dence 6 🗆	Other (Speci	fy)		
On OT VITA rding Physician: th. After this certifications funeral director,	Ë	27. Manner of Death → Natural 5 □ Pendir	28a. Date or (Month	f Injury 28b. n, <i>Day, Year)</i>	Time of Injury	Wo	ıry at rk?	28d. Describe l	how injury oc	curred			
SIO eath. or: A	atic	2 ☐ Accident invest	gation			M 1□							
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To the Hospital or / within 24 hours arer To the Funeral Dire	Med	A	A A 31			29c. Licen	se number		29d. Date si	gned (Month	Day, Year)		
FEF			NX Mecan			D	53691		.70	ly . j:	2. 2009.		
		30. Name and address of person	who completed cause	e of death (Item 23a)) (Type	Print)	1, ,	(. 10 E 2		Post.	ne, nos		
		HTAY RADO	mo 32	vo Du	w	Dans.	Mylvd,	SUIKATI	10,	VUICO.	208 52		

State

Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** July 10, 2009 3:50 P Howard I. Weissleader Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gaithersburg
If Under 24 Hrs. Montgomery
9. Birthplace (State or Foreign Country) Wilson Health Care Center 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**☆** M 2□ F 82 09/11/1926 New York Director 113-16-8749 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location fshow Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, its Widian Exarchant number to military at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Derwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16517 Killdeer Drive 20855 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 DX'es 2 DNo If Yes, Give Year or Dates: 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1944-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 1946 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "na am Injury or other traumatic even." (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4or 5+) Computer Specialist Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard I. Weissleader Sr. Edith Weaver မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16517 Killdeer Drive Derwood, Maryland 20855 Joan B. Weissleader (Spouse) Date 11 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Ju1y 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2009 Metropolitan Crematory Alexandria, Virginia re of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home -10 East Deer Park Drive Gaithersburg, MD. 20877 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Adult faile **Physician** 4 Michie disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Vin Hanken that initiated events resulting in death) Last Due to (or as a conseque ce of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ed by the a detached f P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 (4 Unknown Completed 1426 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has funeral director, page 2 s himme six stem 7-4726a 6 1 ☐ Yes 2 ☑ No Division of Vital or Attending Physician: 25. Was case r fe ed to m ical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fune 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04/15 124 luso 30. Name and address of person who completed cause of death (Item 3a) (Type, Print) 301 12455ELL AUEN LIST GAITHERSBURG, MID 14 ROBERT BIRSCHBACH, NEB 3. Registrar's Signature 31. Date filed (Month, Day, Year) State 14 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2009 July 12, 2:100 **Physician** Lucy Reynolds Wachtman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 8. Date of Birth (Month, Day, Year) | 1. Day, Year) 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Year) 1922 **Funeral** 236-24-7938 Months 1 □ M 2 🗷 F 87 **Director** Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State ns 23a or 28a-f show 1 ☐ Yes 2 TNNo Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Morteal Events. 1403 Gleason Street 20902 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White <u>გ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laney Calvin Reynolds Maude Judy ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Edward Wachtman/Husband 1403 Gleason Street, Silver Spring, MD 20902 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 K Removal from State July 17 4 ☐ Donation 5 ☐ Other (Specify) Elizabeth Chapel Roncerverte, WV 22 Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 21. Signature of Funeral Service Licenses Inc. Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician Physician/Medical the as attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: / 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

the 2

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State

completely

Medical

29a. Certifier

29b. Signature and title of certifie

30. Name and address of

31. Date filed (Month, Pay,

4

and manner stated.

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:32 A M **Physician** July 8, 2009 Wheeler Geneva Elaine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Mechanicsville 26593 Yowaiski Mill Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1 □ M 27 F December 7,1944 Maine 64 007-52-4620 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "scient Evant war is ust by notified at 1 ☐ Yes 2X No Director St. Mary's Maryland Mechanicsville 10g. Citizen of What Country? 10e. Street and Number 20659 USA 26593 YowaiskiMill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ant of Health and Mental Hit: If Item 27 is marked oth y or other traumatic even Alice Boardman Albert Kenney ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26593 Yowaiski Mill Rd., Mechanicsville, MD 20659 July Purdy/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 07/09/2009 Charlotte Hall, MD Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Teleschols Funeral Home, P.A. M00817 P.O. Box 128 Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the complete of Approximate Interval Between Onset and Death ervical static Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Box 68760. Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sf autopsy performe 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral direction 1∐ Yes Certification: To 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Latural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu hours after death. investigation Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlotte Hall, MD 20622 Manoj Panwala, M.D. 31. Date filed (Month, Day, Year) 2009 32 Registrar's Signature Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Mary Virginia Workman 19 09 0115 07 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND WMHS-BRADDOCK CAMPUS Birthplace (State or Foreign Country)
 Maryland Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🔀 F Months Days April 21, 1915 Director 212-38-5646 94 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ns 23a or 28a-f show 1 ¥ Yes 2 ☐ No Director Maryland Allegany Frostburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 175 West Main Street with 21532-U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) of Health and Mental Hygiene.
item 27 is marked other than "natural", or items other traumatic event, in Modeal Examine management. 14. Race - American Indian, 11. Marital Status Black, White, etc 1√Never Married 2 Married Saltimore, Maryland 21215-0036 1 □ Yes 2 No Specify Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence O. Workman Margaret Smouse ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12500 Old Legislative Road Frostburg Maryland 21532-Dorothy Workman sister-in-law 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H
Important: If iter
any injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 22, 2009 Maryland Frostburg Frostburg Memorial Park 22. Name and Address of Facility 21. Signature of Funeral Service License Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive 2 years disease or condition resulting in death) / /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the burial-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 5 Other (specify) urs after death.

eral Director: After this certificate has been signed by the ifiled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Mean Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

within 24 hou

To the Funer

completely fil 5 ARS

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walch Rd Cumberland 925 Bishop WONSOCK 32. Registrar's Signature

29c. License number

00055325

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1^{Day} **Physician** 2009 10:30 A M Naomi Elizabeth Waite /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6217 Timmons Rd. 21863 Worcester 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 9/23/1913 Months Days Hours Min. 1 □ M 2**X** F 95 213-60-9380 MD Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Show ges 1 and 2 should be filed within 72 hours after death with the Maryla tt of Health and Mental Hygiene. Lift files 72 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Modical Examinar must burnaffied at 1 ☐ Yes 2X No Director MD Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6217 Timmons Rd. 21863 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ð If Yes, Give Year or Dates: Specify Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ephraim W. Townsend Mary Cropper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-Department of Health a Important: If item 27 is any injury or other trau once. 6217 Timmons Rd., Snow Hill, MD 21863 Charles L. Waite, III son 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/15/2009 Bates Cemetery Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ervice Licenses ^{12. Name and Address of Facility} Burbage FUneral Home 108 William St., Berlin, MD 21811 23a. Park. Enter the disease or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one, ch line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** heeman disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 0 ed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown s been signed by i should be detach ۵. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Division of Vital Records, à 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? Yes No 1 ☐ Yes 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only e) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mapmer of eath 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. signed (Month, Day, Year) 29d. Date.

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. for State Registrar Certificate of Death Reg. Nd. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 08 2009 Year **Physician** Franklin Ware 03:14 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Southern Maryland Hospital Clinton Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1**X**M 2□ F 14 Oct 1962 Director Unknown Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar awat be notified at DC DC Washington 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20020 2438 Elvans Road #103 Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No Saltimore, Maryland 21215-0036 Specify: Black Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Private 12th 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injuy or other traumatic event, ODGS. 17. Father's Name (First, Middle, Last) Be Vivian Grice Day ဂ္ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2438 Elvans Road SE #103

Washington, DC 20020

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverdale Park Cre 2009

Riverdale, MD 19a. Informant's Name/Relationship (Type. Print) Jeanna Ware - Niece 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Riverdale, MD 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DLMCLaughlin Funeral Home 2019 MLK Jr Ave SE Washington DC 20020 21. Signature Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ne umor ca Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of): IMMUNE Deficiency Viras **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) his certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 1 Inknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ■ Impatient 2 ■ ER/Outpatient 3 ■ DOA 1 Yes 2 Ne Certification: To this completely filled in by the funeral 27. Manner of Death 1 Matural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number

Registrar

State

30. Name and address of pers

JUL 1 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			7	/ Department of Health and M Certificate of Death	_		
	Physici	an	1. Decedent's Name (First, Middle, Last) Tracy Washington		2. Date of Death July 09 ^{Day} 2009 ^{Year} 0123 AM		
/Medi Exami			4a. Facility Name (If not institution, give street and number) Ft. Washington Medical Cent	1	4c. County of Death Prince George's		
Funeral Director			5. Social Security Number 577 − 94 − 2687 Usual Residence of Decedent 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last 47)	8. Date of Birth (Month, Day, Year) May 23 1962 9. Birthplace (State or Foreign Country) DC			
9	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Menlar Hygiene. If filem 21 is marked other than "natural", or items 23a or 28a-f show it filem 21 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director		Town or Location DIE Hills 10f. Zip Code 20748 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	D11-		
21215-0036		Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry		
Maryland 21		To Be Con	12th 17. Father's Name (First, Middle, Last) Earl Washington	Data Entry 18. Mother's Name Joyce M	Private (First, Middle, Maiden Surname) laiden		
~	t and 2 short Health and N tem 27 is ma		19a. Informant's Name/Relationship (Type. Print) Tamara Washington-Daughter	19b. Mailing Address (Street and Number or Rura 5807 Rehling Street Temple Hills, Maryl	al Route Number, City or Town, State, Zip Code) and 20748		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	ce of Disposition (Name of metery, crematory or other place) erdale Park Cre	2009		
Balt	permit. Departimports any Inj		21. Signature of Funeral Service Licensee		McLaughlin Funeral Home SE Washington DC 20020		
760,	eath certificate be executed attending physician and the burial-fransit for use as the burial-fransit	To Be Completed by Physician/Medical Examiner	cal Examiner	3a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Little fundenting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) Due to (or as a consequence)	Si DN price of):	or respiratory arrest, Approximate Interval Between Onset and Death	
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit			hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
Records, P.	w requires that been signed by should be deta		Part II. Other significant conditions contributing to death but not resulti	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
al Reco	ician: The law r certificate has be rector, page 2 sh		To Be	To Be	OF Was see referred to medical		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 ☐
ion or Vital	Phys this al dii				유	유	
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	all Suiside 6 Could not be	ne, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowl of the desired provided in the desired provided provided in the desired	edge, death occurred at the time, date and place, on and/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)		
	To t To t	Σ	29b. Signature and title of certifier	29c. License number D0057632	29d. Date signed (Month, Day, Year)		
R	2 Sta	ite	30. Name and address of person who completed cause of death (Item 2 JAMES MITCHEU MD 1711 LIV() 31. Date filed (Month, Day, Year) 32. Registrar's Signature	3a) (Type, Print) UGSTON RN FT. WASH	41NGTON MD 20744		
	Regist	rar	JUL 1 5 2009 Denus B. Jan	ter .			

DHMH 17 Rev 1/2001

Maris Wilkerson 09-05348

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IK UNK	1	State of Maryland / Department of For State Certificate of	Health and Death	Mental Hy		g. No. 200	9 24187		
Physician	6	degistrar 1. Decedent's Name (First, Middle,Last)	Date of Death Month	h Dav Year	3. Time of Death				
edical Examine		Maris Wilkerson	4c. County of Dea						
	H.	4a. Facility Name (if not institution, give street and number) 16000 block St. Phillips Road 4b. City, Town, or Location of Death Aquasco Prince Georg							
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	_	h(MM/DD/YYYY) 9. E	eign Honolulu		
Director		575-76-0719 1 M 2 X F 45 Yrs		Flours 1 with	June 1	0 1964	Country)		
÷		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion				10d. Inside City Limits		
bow as		MD Prince George's Upper Ma	r1boro				1 X Yes 2 No		
Maryland 28a-f show any dat once.	Director	10e. Street and Number	10f. Zip Code 20772		10	ng. Citizen of What Co USA	ountry?		
with the Maryland ns 23a or 28a-f sho be notified at once.		9600 Meadow Lark Avenue	as Decedent of Hispa	enic Origin? (Sp	ecify Yes or No		erican Indian, Black,		
ath wif	Funeral	1 Never Married 2 Married Armed Forces? If Y	es, specify Cuban, N	Mexican, Puerto	Rican, etc.)	White, etc.			
ifter de al", or ner mt	e F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No				Black		
hours a "natura	g	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	nt's Usual Occupation nost of working life. D	n (Give kind of w OO NOT use retir	vork done red)	16b. Kind of Busines			
5-0036 ed within 72 tygiene. other than "	Completed	9th Admin				Privat	:e		
		17. Father's Name (First, Middle, Last) John R. Santos		s.Mother's Name Sandra F		Maiden Surname)			
2121 Ild be fi Mental narked event,	To Be	19h Mailin	g Address (Street a	and Number or F	Rural Route Nun	nber, City or Town, Sta	ate, Zip Code)		
MD 2 d 2 shou lith and l	-1	Raymond J. Castro/Son 56 M	alama Plac			96720 T20c, Location - City	Town State		
		crematory of o	sition (Name of ceme ther place) e Cremato:		Date 14/2009		e,Maryland		
Page Page		4 Donation 5 Other Specify:	Name and Address of			nkins Fune			
Balti permit. Departir Importi injury c		21. Signature of Function Services Installed	474 Landov	ver Road	d Landov	ver, Maryl	and 20785		
Physician	٦	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, s	uch as cardiac o	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death		
/Medical Examiner	- 4	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):					Death		
		Sequentially list conditions.							
	iner	if any, leading to immediate Due to (or as a consequence of):							
d Sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
0, be executed sician and burial - transi	edical E	d. UNPENDED AMENDED							
60, ate be e thysicia		IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of deli			
OX 6876(eath certificate e attending phy.	ian/	past 12 months?	etal death 3 L other (Specify)	Ectopic pregna	ancy	Month	Day Year		
Box 6876(e death certificate the attending phy ed for use as the b	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown			OS- Did	teh assa usa cantribute	to the cause of death?		
t ≥.t	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause gr	ven in Paπ I.	4	es 2 V No 3 I			
ords, P.O. w requires that is been signed b should be deta					24a. Was		autopsy findings available to completion of cause of		
e law r e has b ge 2 sh	Completed				perf	ormed? deatl	1?		
ital Redicion: The scertificate	Be Co	25. Was case referred to medical		of Death (Check					
Division of Vital Records, tal or detaing Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director.	To B	examiner? Hospital: 1 Inpatient 2 ER/Outpatie	ik 3 DOA	Other A Nursi	ing Home 5	Residence 6 🗸 0	ther: Scene		
Sion of Attending Ph r death. ector: After t		1 Natural 5 Pending FOUND: FOUND:		es 2 V No	Subject wa				
risio r Atten er deat irector n by th	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, sti	reet, factory, office bu	uilding, etc.	or Town	State)	Rural Route Number, City		
Divisospital or A hours after Interal Direct by filled in by	Certification:	4 Homicide determined (Specify) Woods			found 16000	block St. Phillips F			
표 작 로 필		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurrence one) 2 ✔ Medical Examiner: On the basis of examination and/or investig	curred at the time, da gation, in my opinion,	te and place, an death occurred	id due to the cau at the time, dat	use(s) and manner as e end place, and due	stated. to the cause(s)		
To the within 2 To the complete	Medical	and manner stated. 29b. Signature and title of certifier	29c. License			29d. Date signed			
		July 8, 2009							
R 10		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
	tote	Turrent I state and the state		.,					
S Regis	tate								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 **Physician** James Edward Young 2009 12:12pM 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Georges Suitland 5000 Lydianna Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/2/1910 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Months Hours 1 X M 2 □ F 222-10-0751 PA 99 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 k Yes 2 □ No Director Suitland Prince Georges MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20746 5000 Lydianna Lane Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African Maryland 21215-0036 1 ☐Yes 2 No Specify \$ 3 Widowed 4 ☐ Divorced American Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic according Elementary/Secondary (0-12) College (1-4or 5+) Barber Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Edward Young Ellen Iola Ragland ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20706 Betty J. Jones/Daughter 7903 Polk Street, Lanham, MD Saltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State July13,2009 Bellevile, Virginia Belleville Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signalure of Funeral Service Licen 7400 Georgia Avenue, NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive heart failure /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed and burial-tran Due to (or as a consequence of): Box 68760 attending physician certificate be Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? for 1 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, pe 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 ☐Yes 2X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 reral Director; After this filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours a To the Funeral C 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tith

State Registrar address of person who completed cause of death (Item 23a) (Type, Print)

H66665

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JULY 4:00 P.M ALLEN 2009 C. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUMMIT PARK HEALTH & REH. CENTER CATONSVILLE BALTIMORE If Under 1 Year | If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🔽 F **Director** 90 10/30/1918 MARYLAND 213-14-0120 Usual Besidence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Item Adical Exemitation in the Exempted at 1 □Yes 2 □XNo Director MD BALTIMORE NOTTINGHAM 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3901 DARLEIGH ROAD 21236 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 2 **X**Vo 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo þ Specify 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) BOOKKEEPER TRUCKING 12 should be filed w h and Mental Hygien r is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ FRANK CAPONE MARGARET LYONS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si Department of Health an Important; If item 27 is n any injury or other traun THOMAS K. ALLEN/SON 2015 DEVERE LANE CATONSVILLE, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place)

LAKE VIEW MEMORIAL 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/31/2009 | Sykesville, Md GARDENS THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a co be execute burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical certificate the, attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal deat 3

Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autonsy certificate of Vital 1 ☐ Yes 1 ⊡ Yes 2 No 2 🗆 No or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2/1 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at it. 29a. Certifier Medical (Check one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and 29d. Date signed (Month, Day, 30. Name and address of rson who completed cause of death (Item State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Physician 200 Dwight Anders MI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner oseda *lare* Year | If Under 24 Hrs. Social Security Numbe yrs. last birthday) If Under Months 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Yrs Director 217-30-6678 10/14/1933 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at show 1 ☐ Yes 2 X No Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ir than "natural", or items 23a or the Medical Examiner must be r S. A.

14. Race - American Indian, 9740 Bird River Road 21220 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 XWidowed 4 ☐ Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman State Roads Contractor ortant; If item 27 is marked other injury or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John Wayne Anders Florence Edith Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai Melissa Perkins (Daughter) 2056 Kelmore Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2 Cremation 3 Removal from State 4 Domation 5 Other (Specify) Middle River, Maryland Holly Hill Mem. Gard 21. Sanatura (Fundal Septice) 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only she ca ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ue to (or as a consequence of) Examine burial-transi that initiated events resulting in death) Last Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of) Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 2 **⋈** No 1∐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2√1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident (Month, Day Year) Injury 5 Pending investigation To the nospinal within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number certifier 29d. Date signed (Month, Day, Year) DOOGYTSS 25109. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 000

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 07-22-2009 Year **Physician** 2042 P M Shahriyar Atashband /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 07-23-1936 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Months Days Hours Min. Iran 72 218-37-9607 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a. State s 23a or 28a-f show ust be notfiled at 1 ☐ Yes 2 No Director Bel Air Harford MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 USA 202 Idlewild Rd Apt 3C Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 the No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, items Pages 1 and 2 should be filed within 72 hours after der nent of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items tury or other traumatic event, in a fedeal Examination Black, White, etc 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify Specify. White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Humayun Najmi Rustom Atashband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 901 Featherstone Ct Bel Air, MD 21014 Humayun Atashband (Daughter) Baltimore/ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department or Important: If any Injury or 07-27-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. Macphail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** rew) disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Equaritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the attending ph yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 No Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ► ER/Outpatient 3 □ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending PI within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) of Certifier 29b. Signature and

State Registrar Name and address of person with

31. Date filed (Month, Day, Year,

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4-tashband, Shahriyar m8003

sheel Road Bel Air, MD

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2:01 a M Lewis Ray Abshire 23, 2009 July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) August 18,1938 5. Social Security Number 7. Age (In yrs. last birthday) West Virginia Days Hours 1 X M 2 □ F 232-60-6264 70 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Potomac 1 ☐ Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 11824 Trailridge Drive United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1956—1960 Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) IBM Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Perry George Abshire 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice D. Abshire/Wife 11824 Trailridge Drive, Potomac, Maryland 20854 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 28, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee M01544 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Due to (or as consequence of): Due to (or as consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No. 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examirsc must be notified at once.

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Dog

DOD O1 (23)

Baltimore.

Examiner burial-tra Physician/Medical

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completely filled in by the funeral director, page 2 should after death

The law requires that the death certificate be executed Box 68760 Physician: or Attending e Funeral Hospital

Records. Vital of Division

State Registrar

within 2 To the I

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Be Completed 25. Was case referred to medical examiner? 1 Yes 2 No Medical Certification: To 27. Manner of Death
Natural
2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tile of certifier 29c, License number 153612 0712-1-153612 0712-1-tospital Berlin, may 21811 07/23/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Andrea Baier

31. Date filed (Month, Day, Year)

Atkintic General Hospital

32. Registrar's Signature

Harveyl	1	NWOOD BraggS Please Type or Print in Black Indelible Ink. Ensure All Copi	es Are Lea	ible.	
09-05856 ¹		State of Maryland / Department of Health and Mental H	lygiene	0.0	00 01 10
OTTIC OTTIC		For State Certificate of Death	Reg	J. No. 2	119 21 19
Physicia	n/ 1	eqistrar I. Decedent's Name (First, Middle,Last)	2. Date of Death Month	Day Year	3. Time of Death 2340 hrs
Medical Examin		Harvey Linwood Braggs As Excitive Name (if not institution give street and number) 4b. City, Town, or Location of Deat	July 26, 20	4c. County of Dea	th
(4	4a. Facility Name (if not institution, give street and number) Northern Parkway and Woodcrest Avenue 4b. City, Town, or Location of Deat Baltimore		N/A	
Europel		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi		(MM/DD/YYYY) 9. B	irthplace (State or
Funeral Director		214-38-1494 1 XM 2 F 67 Yrs. Months Days Hours Mi	in. 1/22/1		ountry) Md.
		Usual Residence of Decedent			10d. Inside City Limits
/ any		10a. State 10b. County 10c. City, Town or Location			1 X Yes 2 No
and f show	اة	Md. N/A BAltimore	10	g. Citizen of What Co	untry?
Maryl 7 28a-	Director	Toe. Street and Number		USA	
th the		420 BOWER THAT Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Am	erican Indian, Black,
ath wi	Funeral	1 Never Married 2 V Married Armed Forces? If Yes, specify Cuban, Mexican, Puer	rto Rican, etc.)	White, etc.	
". or		1 Yes 2 X No 3 Widowed 4 Divorced If Yes Give Year 1 Yes 2 X No specify:		Specify: B1	
ours af atural camin	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use recommendations and the second s	of work done retired)	16b. Kind of Busines	s/Industry
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003 withir giene her th	Completed	12 Cab Driver 17. Father's Name (First, Middle, Last) 18. Mother's Na	me (First, Middle, M		
21215-0036 ould be filed within 7 Nemal Hygiene marked other than it event, the Medica	Be C	Tamas Down11	y Lee E	3raggs	
212 213 ould be Mark mark ic ever	삙	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			
MD 42 sho th and th and umat		L'Tanya Braggs 1105 Weddel Avenu	le,Balti Date	20c. Location - City	or Town, State
re, s I and freal of Heal		1 Burial 2 XX remation 3 Removal from State crematory or other place)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once	- 9	Metro Crematory 7/	/29 <u>/2009</u>	Catonsvi	ille, Md.
3alt ermit. Separts mport njury		2 Significant Service Income Service Income 22 Remeand Address of Earling Polymers 1300 Eutaw Pl	rs Funei	ral Servi altimore	Md. 21217
		2.5 Part I. Enter the disease, or amplications that caud the safe had enter the mode of dying, such as cardial	ac or respiratory ar	est, shock, or heart	Approximate Interval Between Onset and
Physician /Medical		failure. List only one cause on each line.			Death
aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, b. Sequentially list conditions, b. Due to (or as a consequence of):			
	aminer	cause. Enter Underlying Cause			
Sit G . P	Exan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Division of Vital Records, P.O. Box 68760, fine Hospital or Attending Physician: The law requires that the death certificate be executed fin 24 hours after death. The this certificate has been signed by the attending physician and rule Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	_ <u>_</u> _	d. UNPENDED AMENDED			
, P.O. Box 68760, res that the death certificate be existence by the attending physician be detached for use as the burial.	sician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	
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n of Vital Rec ling Physician: The I After this certificate funeral director, page	1 '	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Panding 28a. Date of Injury 28b. Time of Injury 0000 hrs 1 ✓ Yes 2 No	Driver auto	o/auto collision	
sion attend death. ctor:		2 ✓ Accident Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.		(Street and Number	or Rural Route Number, City
Division of Vital Records, tal or Attending Physician: The law requirents after death. Director: After this certificate has been sided in by the funeral director, page 2 should t	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street		04-4-1	est Avenue, Baltimore, M
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the:			, and due to the ca	use(s) and manner as	s stated.
the H thin 24 the F	Medical	(Check only 1 Certifying Physician: 16 the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, da	te and place, and due	10 (10 00000(0)
To To Cor	₽				(Month, Day,Year)
		(Ableur) O.C.M.E.		July 27, 2009	
1/		3 Home and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
7	L	Latori Locke Mar.			
Regi	State stra	MILL D. O. O.O.O.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#30perDVR, G893, 7/29/09, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 24 Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE ROGIONAL Cotobblat If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Hours Days 1 M 2 □ F 5 Yrs. 9-04-4918 HAITI Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County show must be notified at 1 Yes 2 No BILLSVILLE Director 28a-f 10g. Citizen of What Country? 23a or OUGHBOROUG Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 11. Marital Status injury or other traumatic event, the Medical Examiner permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Specify: BLACIL Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. δ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAREhousillG 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BAPTISTESALOMION 2 19b. Mailing Address (Street and Number or Rural Route Number, City or 19a. Informant's Name/Relationship (Type. Print) BAPTISTE-WIFE 7704 CATHERINE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SILVER SPRING 1-09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 1022060 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar attending physician and consequence of Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year 5 ☐ Other (specify) the 9☐Unknown detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by g 2 No 3 Probably 4 No Nown 1 ☐ Yes completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform After this certificate 1□ Yes Physician: 25. Was case referred to examiner? 26. Place of Death Check onl one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Tes **U** Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manne at eath 28c. Injury at Work? To the Hospital or Attending 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: ₽ 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day Year) 29c. License number 29b. Signature and title of certifier 30. Name 2 -Laurel Regional Hosp. Laurel, MD 20707 31 Date filed (Month, Day, Year) State JUL 29 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 830 2^d4 2009 Racote /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 1227 E. Oliver Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Mgnth, Day:1 Year) 30 9 Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕇 F Months Days Hours Min 213-28-1520 Yrs. MD Director 79 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once. 10b. County N/A 10c. City, Town or Location 10d. Inside City Limits Baltimore Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21202 1227 E. Oliver Street by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □Yes **2□X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No 3altimore, Maryland 21215-0036 Specify: Black Specify: 3 Midowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Esters Hazel Davis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1227 E. Oliver St. Baltimore, MD 21202 George Faidley-daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Greenmount Crematory7/27/09 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD21202 D ar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician heart months disease or condition resulting in death) /Medical Due to (or a consequence of): **Examiner** IVular Securities is any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant et time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 IANo 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 X No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate 2 No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 Yes 2 XNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

P.O. Division of Vital Records, within 24 hours after death To the Funeral Director: completely filled in by the

0

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Debru

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Withs

DHMH 17 Rev 1/2001

700 Geipe Rd.

Registrar's Signature

29c. License number

D0055206

Ste Zuo Cotonsville,

29d. Date signed (Month. Dav. Year)

27, 2009.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Marjory Burg 22 2009 uli /Medical 4a. Facility Name (If not institution, give street and number) 4c. Counfy of Death 4b. City, Town, or Location of Death Examiner BACTIMOVE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Oct. 4, 1915 SAINT AGNES HEALTHCORE 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Country) Pennsylvania Months 1 □ M 2 🖾 F 93 166-03-8236 Director Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner is ust be notified at 1 ☐ Yes 2 ☑ No Baltimore Catonsville Maryland Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with it. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and 10 july or other traumatic event, the Medical Exercises 200.0. 10 Edmondson Ridge Road 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo White If Yes, Give Year or Dates Specify Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Transportation Aide Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Earl Brown Bessie Yeatman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Burg Daughter 6301 North Charles Street; Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Union Hill Cemetery 17/29/2009 Kennett Square, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Se LICH MO1537 1630 Edmondson Avenue; Catonsville MD 21228 Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION hour /Medical Due to (or as a consequence of): Examiner CUTE SEPTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and burial-tran Due to (or as a consequence of) Physician/Medical detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 20 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ATHEROSCIEDOTIC CORONARY ARTERY DISEASE Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed: certificate 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No Physician: completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ision Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated. within 2 To the I the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)77648 22,2009 my Clino

State Registrar

DHMH 17 Rev 1/2001

900 SOUTH CATON AVENUE BALTIMORE, MARYLAND 21229

ne and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jerome I. SWIDER MD

31. Date filed (Month, Day, Year)

State Registrar Carol Allan, MD

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 2009 JULY 27 4:34 A MICHAEL CHRISTOPHER BISSETT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth **Funeral** Days Year) Hours 19, 1956 Ohio Director 301-52-3313 53 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 X No Funeral Director Maryland Harford Abinadon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 USA 1400 Valley Forge Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 7 is marked other than "natural", traumatic event, the Medical Exe Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Baking Company Bakery Superintendent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Kathleen (unk) Sweeney James (unk) Bissett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 Valley Forge Way, Abingdon, Maryland 21009 Barbara L. Bissett / Wife Important: If item 2 any Injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland Service Corp. 8-1-09 21. Signatur Funeral Service Licensee McConas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part I/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician urdiac dyrythmi disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MANOUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner and burial-trai resulting in death) Last Due to (or as a consequence of): physician Hypa cholesta Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Por 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No Probably 4 Unknown Completed peen Ho & place Abuse 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? 1 □ Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I or Attend after death Director: 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Hospital within 24 hours a

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State Registrar 29b. Signature and titl

31. Date filed (Month, Day, Year,

Sch

00036951

volerberg, M.D. 9114 Philadelphia Rd., Ste #108 Battimore, MD21237

29d. Date signed (Month, Day, Year)

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year JULY **Physician** 26, 8:05 A M HARRY JUDD BONIFACE /i/ledical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARFORD FOREST HILL HEALTH AND REHABILITATION FOREST HILL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Days Hours 1 **2**M 2 □ F 215-16-6238 87 Director 12, 1922 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Evaniner must be notified at 1 ☐ Yes 2X No Directo Bel Air Maryland | Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 918 Candlelight Ct. 21015 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼No Specify 3√ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Utility Contractor <u>Construction Manager</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evones. Fritz (nmn) Boniface Louise (nmn) Judd ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry R. Boniface / Son 918 Candlelight Ct., Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Episcopal Cem. 7-31-09 Forest Hill, Maryland 21. Signature of Funeral Service License McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part r. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 50 reek disease or condition resulting in death) as a consequence of) QARS Me Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

been signed by the attending physician and should be detached for use as the burial-transit completely filled in by the funeral director, To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

of Vital Records, P.O. Box 68760,

Division

Be ၉ Certification:

1 🗆	Yes	2	INO	3 🗆 PI	ораріу	4)_On	KHOW
24a. Was auto perfo 1 □Yes	psy ormed	? No	24b.	Were au prior to death? 1 □ Yes		ndings av ion of cau No	ailabl ise of
hack only	ana)						

1 ☐ Yes 2 ☐	10
27. Manne eath	
1 Natural	5 Pending investig
2 Accident	investig
O Cuinido	6 Could n

29a. Certifier

25. Was case referred to medical examiner?

ation not be determined 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 2 🗌 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

26. Place of Death (C

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT DUNCAN DR. 31. Date filed //

615 W. MACPHALL ROAD Registrar's Signa

21014 MD. BEL AIR,

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician /Medical 2009 9:16a M 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 5. Social Security Number 218-58-9265 8. Date of Birth Month Day, 5. 13. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 56 Months Hours Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h Chunty "natural", or items 23a or 28a-f show dical Examiner must be notified at Baltimore 1 Yes 2 □ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21217 Monroe USA Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. BS NOT use retired) 15. Decedent's Education injury or other traumatic event, the Medical (Specify only highest grade completed) Elementary/Secordary (0-12) College (1-4 or 5+) and Mental Hygiene. iomestic atter's Name (First, Middle (Ast) Be Helen Har per 9a. Informant's Name/Relationship (Type. Print Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mD 21223 Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pikesville, onD 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Naugho C. Kreine 5151 Bauto, Nat'l P: Ke
23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Mierto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Box 68760, attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Dav Year completely filled in by the funeral director, page 2 should be detached for 5 Other (specify) 1 Yes 2 been signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an berformed? 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ρ within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Janie. 6/15/12 31. Date filed (Month, Day, Year) JUL 28 2009 32 Registrar's Signature State back

DHMH 17 Rev 1/2001

Registrar

09-05864

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Coleman	State of Maryland / Department of Health and Mental H 1-For State	ygiene Reg. No.	2000 21.20			
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death			
Medical Examiner	Robert L. Coleman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month Day July 27, 2009	0420 hrs			
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hospital Center Cheverly		ice George's			
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Mir		YYYY) 9. Birthplace (State or Foreign			
Director	248-74-6683 1 X M 2 F 64 Yrs.	6/24/1945	Country) SC			
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits			
and show nee.	M.D. Prince Georges Bowie		1 Yes 2 No			
tith the Maryland 23a or 28a-f show any notified at once. al Director	10e. Street and Number 10f. Zip Code	ľ	of What Country?			
ath with the items 23a of ist he notifical Distribution of items 100 o	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No- 14.	Race - American Indian, Black,			
r death with or items 23 must be no Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puert Yes 2 No	· ·	white, etc. ec.ly.Lack			
25 70 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once eted by Funeral Director	3 Widowed 4 Divorced If yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		ecifyd of Business/Industry			
72 hour	Elementary/Secondary (0-12) College (14 or 5+) There are Appendix and the property of the pr	tired)				
15-0036 filed within 72 hours after Hygiene. d other than "natural", the Medical Examiner.	5+ Nurse Anesthetist	e (First, Middle, Maiden Su	edical			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Comple		ia Spencer				
D 2121 should be fill and Mental It is marked matic event, To Be		Rural Route Number, City	or Town, State, Zip Code)			
aur Zaur Zaur Zaur Zaur Zaur Zaur Zaur Z	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	* ***	cation - City or Town, State			
2	1 A Burial 2 Cremation 3 Removal from State crematory or other place)	8/1/2005 i	Pikesville, M D			
Ealtimo	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	lie Funeral Home	es of Balto. County			
	9200 Liberty Road, Ra 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	ndallstown, MD or respiratory arrest, shock	21133 or heart Approximate Interval			
Physician /Medical	failure. List only one cause on each line. Immediate Cause (Final disease a Ethanol and narcotic intoxication with the cause (Final disease a Ethanol and narcotic intoxication with the cause (Final disease a Ethanol and narcotic intoxication with the cause (Final disease a Ethanol and narcotic intoxication with the cause (Final disease a Ethanol and narcotic intoxication with the cause (Final disease) and the cause of the cause o		Between Onset and Death			
⁻xaminer	or condition resulting in death) Due to (or as a consequence of): Complications					
Į.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
ted nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
and transit		5 10/0/00 ጥጥ				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit certification: To Be Completed by Physician/Medical Ex	X UNPENDED AMENDED 23a,P11 27, 28a-1,permE, g899		Date of delivery			
Sox 6876 Jeath certificate e attending phy for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg		onth Day Year			
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that the detached			e contribute to the cause of death?			
Records, P.(The law requires that ficate has been signed ; page 2 should be deta	Cutting wounds of arms and neck	1 Yes 2 1	No 3 Probably 4 Unknown 24b. Were autopsy findings available			
cords, law requir		autopsy performed?	prior to completion of cause of death?			
tal Recian: The certificate ector, page		1 Yes 2 No	1 Yes 2 No			
Vital sysician this certi	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nur.	sing Home 5 Residence				
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. reral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.		ingested dr	occurred subject rug and ethanol and			
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune	Pending Investigation 2 Accident Accident Pending Investigation 2 2 Accident Pending Investigation 2 2 Accident Pending Investigation 2 2 2 Accident Pending Investigation 2 2 2 Accident Pending Investigation Pending Inve		Number or Rural Route Number, City			
Div pital or ours after eral Di	3 X Suicide 6 Could not be determined (Specify) found at home	Bowie, MD	218 Quadrile Lane			
Di To the Hospital - within 24 hours a To the Funeral L completely filled		my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
To the Ho within 24 To the Fu Completely	and manner stated. 29b, Signature and title of configure 29c. License number		ate signed (Month, Day, Year)			
	Pat-Chone-Poller O.C.M.E.	July 2	28, 2009			
	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltim	ore MD 21201				
Stat		0.0, NID 21201				
Registra						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 26 26 **Physician** 2009 July 10:35 A M Juan del Castillo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac 10809 S. Glen Road 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 28, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 ፟M 2 □ F 1921 Director 070-24-2114 87 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 🔽 No Director Potomac Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20854 United States 10809 S. Glen Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:1942–1981 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of College (1-4or 5+) 5+ Elementary/Secondary (0-12) Senior Executive Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Rafael del Castillo Ruth Behr ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 10809 S. Glen Road, Potomac, Maryland 20854 Joan M. del Castillo/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Gabriel's
Parish Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State July 30, 2009 Potomac, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. 2mt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 Week Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 5 Years Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Atrial Fibrillation 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □ No 1 □Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 1 \(5 \) Residence \(6 \) Other (Specify) 1 X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

To the Hosp

Baltimore, Maryland

Box 68760.

P.O.

Records.

of Vital

Division

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person w

31. Date filed (Month, Day, Year)

Christopher Dunford,

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

D31839

615 West Montgomery Avenue, Rockville, Maryland 20850

July 27, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 25, 5:12 AM JULY 2009 MICHAEL FRANCIS CONNOR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE TOWSON GILCHRIST CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/17/1923 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 XM 2 ☐ F MARYLAND Director 219-18-4185 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE PARKVILLE Funeral Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 2809 UPRIDGE COURT APT. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Black, White, etc. Yes 2 Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ If Yes, Give Year or Dates: WWII 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry SOCIAL SECURITY College (1-4or 5+) Elementary/Secondary (0-12) ADMINISTRATION PROGRAM ANALYST 2 YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLORENCE WALTER ၉ JOSEPH P. CONNOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau once. 2809 UPRIDGE COURT APT. D PARKVILLE, MD 21234 SARAH CONNOR/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY MEM. 7/30/2009 TIMONIUM, MD 4 ☐ Donation 5 ☐ Other (Specify) GARDENS 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses MO0217 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. art1. Enter the dis. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final congestive heart failure Frd-Stage **Physician** cars disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Amy loidosis Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burlal-trans Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) War Pice

Injury at 28d. Describe how injury occurred Fell of home welking 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 5 Pending investigation with walker, got Oxygen tubing timp fail 1 Natural 5:00 PM 1 ☐Yes 2 No death, July 14,2009 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2809 D Upridge Ct. PARVIlle, MU 2135 4 - Homicide Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

A. Riley GBINC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

32. Registrar's Signature

DHMH 17 Rev 1/2001

N. Chroles St. Balto. md 21204

29c. License number

29d. Date signed (Month, Day, Year)

July 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 26, 2009 Physician Year July 11:50 AM Bernard H. Cook /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
1920 West Virginia 8. Date of Birth (Month, Day, Year)
Nov. 3, 19 5. Social Security Number **Funeral** Hours 1 X M 2 □ F Director 88 234-28-3118 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 □Yes X No Funeral Director Maryland Harford Forest Hill 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21050 2820 Grier Nursery Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2 🛛 No Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nyanza Faye Belcher Charles H. Cook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2820 Grier Nursery Road, Forest Hill, Maryland 21050 Mildred L. Cook / Wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 8/1/2009 Bel Air, Maryland 21. Signature Juneral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK **Physician** DA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that is introduced to the conditions of the cond Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 687 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 2 No 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Chronic obstructive pulmonery direase 1 X Yes 2 No 3 Probably 4 Unknown Curonary orthry disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **2** No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1
Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signatore and title of certifier

State Registrar

MOCOLOGICO

Bernar

D0057619

2. Registrar's Signature 2014

JULY 26, 2009

Oshua MF Kubatere, MD

Joshua Rubenfeld, M.D.

JUL 29 2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 27 7:26 pm 2009 Caroline E. Domeier /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Number 6. Sex BALTIMORE 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country) Virginia 9. Birthplace (State or Foreign Social Security **Funeral** Months 1 M XX 216-28-9964 76 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f shov ner must be notifled at 1 Yes 2000 Director MD Baltimore Reisterstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 U.S.A. 631 Beverly Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž Ž No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married ō 1 ☐ Yes X2X No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Tussing Jackson Beale Sutherland 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 631 Beverly Rd. Reisterstown, MD 21136 Henry E. Domeier 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Memerial 20c. Location - City or Town, State 20a. Method of Disposition X1X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Ø ther (Specify) Park 7/30/09 Sykesville, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DRI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUNG CANCER METASTATIC Small Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No DIVERTICULOU 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 W Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attending P after death. I Director; After i d in by the funera (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospita 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier teun Shava MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharma MD Mospital Sina 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 29 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05766 State of Maryland / Department of Health and Mental Hygiene Andrew A. Dowley Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 23, 2009 Year 1223 hrs Andrew Dowley | Α. Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Country) Director Jan. 10,2007 217-77-2034 2 1X M Yrs 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No or 28a-f show Baltimore City MD N/A items 23a or 28a-f shoust be notified at once. death with the Maryland Director 10g. Citizen of What Country' 10f. Zip Code 10e. Street and Number United States 21206 4803 Althea Avenue 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Married Yes White Specify: Yes 2 X No specify: Pages 1 and 2 should be filed within 72 hours after Divorced If Yes. Give Year "natural", \$ 6b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) ment of Health and Mental Hygiene. tant: If item 27 is marked other than " or other traumatic event, the Medical. 21215-0036 N/A N/A Dependant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julie A. Kirkpatrick

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter G. Dowley 19a. Informant's Name/Relationship (Type, Print) 4803 Baltimore, Maryland 21206 Althea Ave. Mr. Peter G. Dowley (Father) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition timore, crematory or other place) Burial 2 X Cremation 3 Removal from State 7/31/2009 Towson, Maryland Hilltop Service Corp Other Specify: 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Juneral Service Licenses Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ailure. List only one cause on each line /Medical Death Sudden unexplained death in childhood Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED XUNPENDED attending physician or use as the burial 23a,27, permE, g897 11/9/09 TT Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 8 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ρ signed 1 Yes 2 ✓ No 3 Probably 4 Unknown 2 σ. Completed Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? certificate has page 2 s ✓ Yes 2 ✓ Yes 2 Νo 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifit 25. Was case referred to medical Division of Vital Be Hospital: 1 examiner? Other, Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 DOA 1 ✔ Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending completely filled in by the Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 W Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Melissa Brassell, MD 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 24, 2009

29

30. Name and address of person who complet d cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Leonard Harry 5:59PM Enge1 24 Ju₁v 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 5104 Hamilton Street Baltimore City N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) Date of Birth (Month, Day, Year) Hours Months Days 1 XM 2 □ F 212-44-9956 Aug. 8,1946 62 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1⊠Yes 2 No Marv1and N/A Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 5104 Hamilton Street United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Year Mason Masonry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Washington Engel Evelyn Rosalie Deitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Samuel Gude 5104 Hamilton Street Baltimore, Maryland (Partner) 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 7/30/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset And Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to forms a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 X Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

ò

Completed

Be

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercises must be redified at

within 72 hours after

12 should be fill the and Mental F 7 is marked oth

s 1 and 2 s of Health ar Item 27 is

permit. Pages 1 a
Department of He
Important: If Item
any Injury or othe

Baltimore, Maryland 21215-0036

Box 68760

P.O. |

Division of Vital Records,

Physician:

To the Hospital or Attending

hours To the Funeral

within 24

certificate be

Examiner burial-trar Physician/Medical the use for detached þ Completed page 2 should Be

and attending physician the ģ signed I has certificate Certification: To After this funeral s after dea...ral Director: After filled in by

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

29a. Certifier

24a. Was an autopsy perform 1 ☐ Yes 26. Place of Death (Check only onle)

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sig 28625

address of person w 30. Name an o completed cause of death (Item 23a) (Type, Print)

3100 St. Paul St, Suite 5 Boltimo

State Registrar

Medical

Year)

Date filed (Month, Day,

32. Registrar's Signatule

ESTRUCK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19 AM **Physician** EUNE 2009 JULY au 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BAUTIMORE BAYVIEW MEDICAL CENTER JOHNS HOPKINS 8. Date of Birth (Month, Day (Year)) 927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min Maryland 217-22-8856 81 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a, State 10b. County d other than "natural", or items 23a or 28a-f shor event, the Medical Evanturar must be notified at 1 ☐ Yes 2 ☐XNo Director Dunda1k Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21222 United States 300 Oakwood Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 Yes 2 No Specify Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry Mechanic 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes L. Tramberg Joseph D. Eline 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1894 August Ave. Dundalk, Maryland 21222 Mark Eline (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville V.A. Cem. 7/29/2009 Crownsville, MD 4 Donation 5 ☐ Other (Specify) of Funeral Service Licenses 21. Signatu Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final disease or condition resulting in death) **Physician** ACUTE 1400 RS RESPIRATORY /Medical Due to (or as a consequence of): Examiner 140402 Sequentially list conditions, if any leading to in mediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed VEN-RICULAR HURS burial-tran and Due to (or as a consequence of) Box 68760, attending physician for use as the buria DAYS Physician/Medical YPERGLYCEMIA IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Year 5 Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **□**No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State

DHMH 17 Rev 1/2001

Registrar

EASTERN AVENUE BAUTIMORE, MD

940

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2420 23 2009 LINDA JOYCE EDWARDS JULY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE RANDALLSTOWN SEASONS HOSPICE 8. Date of Birth (Month, Day, NOV. 23, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year. Days 1 □ M 2 🛛 F ΝC 61 Director 218-44-9936 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It is Medical Examins or must be notified at 1 XYes 2 □ No Director BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 3615 MOHAWK AVE. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 X If Yes, Give Year or Dates: 2 **X**No Specify: BLACK 1 Never Married 2 Married 1 □Yes 2 🛚 No Specify: 3 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSING HOME NURSE (LPN) 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LURA DELL COX ပ ROBERT J. LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3615 MOHAWK AVE., BALTIMORE, MD 21207 KEVIN D. EDWARDS/HUSBAND 5500 O DONNELL State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages
Department o
Important: If i
any injury or
once. 07/31/2009 | BALTIMORE, MD 21224 4 ☐ Donation 5 ☐ Other (Specify) TRINITY 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licenses 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part T. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ast only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician STAGE CARDIOMYOPATHY a. END /Medical Due to (or as a consequence of): Examiner SCHOMIC HOART BISEASI if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed CORONNEY ARTERY DISLAS and attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s autopsy performed? certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 110 SPICE Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

Ö Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

Maryland 21215-0036

Saltimore.

Registrar

DHMH 17 Rev 1/2001

Debbie

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated.

Burton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

1445931

29d. Date signed (Month, Day, Year)

2835 Smith Avenue Surte 203 Baltmare MPziza

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 4:01 AM -veemar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If pot institution, give street and number) Examiner Heights 316 Hot Tark If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 18 Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 242-56-779: Days Hours Min. arolin 1 □ M 2 🔽 1 North May Director Usual Residence of Decedent 10d. Inside Cjty Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director tomore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be 1a 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21212 Health a NIECE Gwendolyn 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ō Important: If it any injury or o 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Kaltimore 400 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Baltimore, MD 21201 Approximate Interval Between Opert and Death Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ONGEST **₽**hysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surrecquerior of): Examiner burial-transit 3 Hospital or Attending Physician: The law requires that the death certificate be execut 24 hours after death.
9 Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-tran P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) □Yes 9 | Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>6</u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only re) Be Other: 4 Nursing Home 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Beath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 1009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ju^Minth 23, 2009 Rae Zimmerman Fisher 12:47P M 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Gilchrist Hospice Towson 8. Date of Birth (Month, Day, Year) 07/10/1918 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 232-01-8154 1 □ M 2 耳 F Months Days Hours Min. WVA 91 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location Baltimore Towson 1 □Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21286 USA 522 Wilton Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No White Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Hospital Elementary/Secondary (0-12) Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Caroline Beatrice Snyder Harry Zimmerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 Wilton Rd. Towson, MD 21286 19a. Informant's Name/Relationship (Type. Print), Charles Fisher, III/Son July Date 28, 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crem. Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility AFA/Stephen D.Lohrmann T.A. 21. Signature of Funeral Service Licensee 8717 Green PAstures Dr. Balto, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reaks 4 ang Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to /r as a consequence of): Due to (or as a consequence of): 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 □Yes 2 □ No 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) pice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

ud 2 should be filed within 72 hours after death with the Marylar th and Mental Hyglene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is the continued.

permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked oth any Injury or other traumatic event once.

Baltimore, Maryland 21215-0036

15hu FAC JUN 35,200) Division of Vital Records, P.O. Box 68760,

Attending I

or A

To the Hospital within 24 hours a To the Funeral D

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Physician/Medical 2 Completed Be Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2 No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2√No

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Charles St. Balto. md Z. 20x

27. Manner of Death 2 ☐ Accident 3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be

determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 60

State Registrar

Medical



uno

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day July 23, 2009 4:51 P John Joseph Fear Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Harford Air 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Hours Days Min 1 🔀 M 2 🗆 F 26, 1949 Pennsylvania 60 215-56-5550 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Maryland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21040 640 Boxelder Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Tyes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Recycling 12 Warehouse Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Joseph Fear Sr. Dorothy Catherine Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Autumn L. Fear / Wife 640 Boxelder Drive, Edgewood, MD 21040 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7-27-09 Towson, Maryland Hilltop Service Corp. 21. Signature of Funeral Service License McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CIRRHOSIS Due to (or as a consequence of): RENAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2****₩0 1 Yes 1 Department 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

/Medical **Examiner** and Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria cate has been signated by page 2 should b Division of Vital director, Hospital or Attending Pl 24 hours after death. Funeral Director: After t filled in by the

Physician

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Examiner

and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Modical Exactions counting as

injury or other traumatic

Department of Health an Important: if Item 27 is any injury or other trauonce.

Physician

Pages 1

Maryland 21215-0036 490 6

Baltimore,

Physician/Medical Completed Certification: To Medical

29a, Certifier (Check only one)

1 Watural

2 Accident

3 🗌 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintened at the time, date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 □Yes 2 □No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 upper Chesapeak pr. Bei Ac, mp 21014 Khalid Puthawala

Date filed (Month, Day, Year) JUL 29 2009

5 Pending investigation

6 ☐ Could not be

Registrar's Signature

State

Registrar

24 hours a

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Denedent's Name (First, Middle, Last) 5AM ounty of Death Location of Death 4b. City, Town, or cility Name (If not institution, give street and number) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. Year If Under Age (In yrs. last birthday, Social Security Number Min Days Months 1 M 2 □ F Michigan Oct 27, 1950 58 364-50-4306 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1X Yes 2 No Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21225 3219 Gulfport Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify 1 ∐Yes 2 No Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Sears Elementary/Secondary (0-12) College (1-4or 5+) Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 12 17. Father's Name (First, Middle, Last) Adelaine Pack James J. Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 734 Faraday Place, NE Washington, D.C. 20017 Nellie Callahan 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State Burnwood, Maryland 08/03/09 Fort Lincoln Cemetery Donation 5 Other (Specify) 22. Name and Address of Facility gnature of Funeral Sq Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervat Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final CLOON disease or condition resulting in death) Due to (or as a consequence of) 1011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ar as a consequence of) Due to (or as a consequence of) 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

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attending physician for use as the buria

s been signed by the a should be detached t

page 2 s certificate

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within 24 hours a To the Funeral C

Hospital

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executed

or Attending Physician: The law requires that the death certificate be

Division of Vital Records, P.O.

Box 68760,

Physician /Medical

Examiner

Funeral

Director

28a-f shov

Director

Funeral

Completed by

Be

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21.

ar than "natural", or items 23a or 28a-f sho tre Wedical Evané ser a ust be netified at

is marked other than

traumatic event,

within 72 hours after death with the Maryland

filed

Mental

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permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trat

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

Examine Physician/Medical Completed by Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant 9 Unknown

1 ☐ Yes

4 Homicide

(Check only one)

29a. Certifier

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ____ f

26. Place of Death (Check only one)

ital: 1 ☐ Inpatient 2	ER/Outpatient	3 □ DOA	Other: 4			5 Residence	
28a. Date of Injury (Month, Day, Yea	28b. Time of	28c.	Injury at Work?	2 □No	28d.	Describe how in	ury occurred

Manner of Death Natural 5 Pending investigation 2 Accident 3 Suicide

25. Was case referred to medical examiner?

2 240

6 ☐ Could not be

Hosp

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

50 2000

29c. License number U

29d. Date signed (Month, Day, Year)

of death Item 23a) (Type, Print nerson who comple ed cause Name and address of G

31. Date filed (Month, Day,

Registrar's Signature

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05684 State of Maryland / Department of Health and Mental Hygiene Samuel Green 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 20, 2009 1510 hrs Samuel Green Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 825 N. Luzerne Street If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Davs 7-14-1950 MD Director 59 1 x M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State X Yes 2 No N/A Baltimore t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene.
rtant: If item 27 is marked other than "natural", or items 23a or 28a-f show y or other traumatic event, the Medical Examiner must be notified at once. MD Director 10f. Zip Code 21 20 5 10g. Citizen of What Country 10e. Street and Number 825 N. Luzerne Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funeral 11. Marital Status

1 X Never Married 12. Was Decedent Ever in U.S. White etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 Married Yes X Black Specify specify: Divorced If Yes, Give Year Widowed ⋧ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) Unemployed Unemployed Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thelma McCray Melvin Green Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7507 Heatherfield Dr Balto Md 21244 Mildred Barnes-Sister Date 20c. Location - City or Town, State 20a Method of Disposition

1 Burial 2 Cremation 3 20b. Place of Disposition (Name of cemetery, Tformortone Cemetery 7-24-200\$ Balto, MD Removal from State Donation 5 Other Specify: F/H March East 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MD 21202 1101 E. North Avenue Balto, Approximate Interval 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical ttending physician a AMENDED UNPENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.0. contributing to death but not resulting in the underlying cause given in Part I. 2 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of nerformed? death? Yes 2 V No this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 V Natural 1 Yes 2 No Pending

he Hospital or Attending Physician: Th in 24 hours after death. he Funeral Director: After this certifica pletely filled in by the funeral director, pa Certification: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 or Town, State) Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

OGME \

Melissa Brassell, MD

30. Name and address of person who complete cause of death (Item 23a)

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 21, 2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Frank Genco, Jr. Certificate of Death Registra 1. Decedent's Name (First, Middle.Last) 2. Date of Death Physician/ Month Day July 21, 2009 Year 2336 hrs Medical Examiner Frank J. Genco, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Bayview Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Months Days Hours Director 05-17-1962 Country) NV 1X M 2 F 47 216-80-2478 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Ž 10a State Inh County Yes 2 X No f show Bel Air once MD Harford Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Montal Hygiens, or interns 23a or 28a-f sho or of there 27 is marked other than "natural", or items 23a or 28a-f sho or other tranmatic event, the Medical Examiner must be notified at once 10g. Citizen of What Country 10e. Street and Numbe 10f. Zip Code USA 21014 듑 294 H Canterbury Rd Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes Specify: White 1X Yes 2 No specify: 4 X Divorced f Yes, Give Year 3 Widowed þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Current Electric Electrician 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Donati Frank J. Genco, Sr. Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Tulane Ct. Churchville, MD 21028 Michael Genco 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 07-27-2009 Baltimore, MD Bayview Crematory Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of BelAir roumon 610 W. MacPhail Rd Bel Air, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease of injury that imitiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atte 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed icate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 🗸 Yes 2 No No 26.Place of Death (Check only one) the Hospital or Attending Physicians 25. Was case referred to medical Division of Vital Be examiner? Other, Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 🗸 Yes ပ္ No 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification: Operator of motorcycle that struck fixed object FOUND: 1 Natural Yes 2 V No filled in by the f Pending 24 hours after death. Jul 21, 2009 2350 hrs 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Southbound 702 and Eastern Boulevard, Baltimore, MD determined (Specify) Major Road / Highway To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number July 22, 2009 O.C.M.E. no 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** old wike 2 2009 JUL /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner BALL: MORE VA Medical Center Altimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min. 1**X** M 2□ F Months Days Hours 262-32-0654 Director 05/30/1932 FL Usual Residence of Decedent Maryland 10d, Inside City Limits 10a. State 10b. County 10c. City. Town or Location Show iral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2 No Funeral Director M Baltimore Ramial Istown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
snt: If item 27 Is marked other than "natural", or items 23a or 9017 Meadow Heights Road 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 2√□ No 1 ☐ Yes Specify: Completed by Specify: Black 3 Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlahan Steel 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be : If item 27 Is marke or other traumatic RosaLee Terry 2 Aurthur Goldwire 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Reute Number City or Town, State Zip Code)
2017 Meadow Reignts Road, Kat Hallstown, In 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of I
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Cemetery 7/29/2009 Owings Mills, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Wile Funeral Homes P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Friture From PNEUMONIA Immediate Cause (Final **Physician** RESPIRATOR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): pital or Attending Physician: The law requires that the death certificate be executed ours after death.

earl Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 ■Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗷 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 1710145255 5+1

Registrar DHMH 17 Rev 1/2001

State

Stephanie

31. Date filed (Month, Day, Year)

10 NO Eth GREENEST BALTIMORE.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALES KOW

Stein MD

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:45 am **Physician** Julu 900_{0} 23 HARRIET M. GRIFFIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A KESWICK NURSING CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Months 12-7-1932 MARYLAND Director 215-30-2319 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with n and Mental Hygiene.
Is marked other than "natural", or items 23a or: 2315 WINEBERRY TERRACE 21209 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12-DIRECTOR OF FINANCIAL AIDE TOWSON UNIVERSITY -6- Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ HARRY H. JONES ETHEL B. BYRD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2315 WINEBERRY TERRACE BALTIMORE, MARYLAND 21209 CHARLES GRIFFIN (HUSBAND) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 4 Donatio 2 Cremat 3 Removal from State ¢ARRISON FOREST VETERANS OWINGS MILLS, MARYLAND 5 Other (Specify) JONATIAN D. HIBNER Name and Address of Facility REDD FUNERAL SERVICE 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line, Imme to Cause (Final disease or condition resulting in death) hysician meta Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the use as attending properties as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 Yes 2 No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director 7 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00064788

State Registrar 31. Date filed (Month, Day, JUL 29

Year) 2009

DHMH 17 Rev 1/2001

ROYAL AUE BALTIMORE

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jul 21, 2009 ear 5:35 a **Physician** David A. Higgins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Joseph Richey Hospice, Inc. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Jun 28, 1926 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 □ F Wash., D. C. Director 83 578-28-2012 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the "hadical Examina must be notlined at 1 Yes 2 No Director N/A **Baltimore** Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21213 1207 North Monfort Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☐XNo Specify Specify. Black þ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", any Injury or other traumatic event, the Medical Exa 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Private Company Window Washer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia Higgins Valston E. Higgins ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3219 Elmley Avenue Baltimore, Maryland 21213 Antonia Fulton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State 08/01/09 Baltimore, Md. Mt. Carmel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Months metastatic non Carcinoma **Physician** -Simall /Medical Due to (or as a consequence of): Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-tran Due to (or as a consequence of) Records, P.O. Box 68760; attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) □Yes 2□No ed by the detached 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. ð 1045 1 Yes 2 □ No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy oerform mentica certificate 1 □Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 6 Mother (Specify) TOSpice Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To Division of funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 24 hours after deatle Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29d. Date signed (Month, Day, Year) Physiciau, 29c. License number 29b. Signature and title of certifier 0 of pleath (Item 23a) (Type, Print) & MD, 4924 Campbell Blvd, Suite 200 30 Name and address 31. Date filed (Month, Day, Year) State 29 2000 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 606 Woodbine Himo If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min. 1 □ M 2 🖫 F Months Carolina 220-22-2752 North Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SA "natural", or items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 100 1 ∐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Item 100 Elementary/Secondary (0-12) College (1-4or 5+) House with 10 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) saltimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State rounsville, Vousville. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur - Funeral Service L - ee 22. Name and Address of Facility Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiae or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner gaquendamy lies conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed and burial-tran Due to (or as a consequence of P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No certificate e Hospital or Attending Physician: 724 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide completely filled Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2135 W. Belredue of death (Jen 23a) (Type, Print) 30. Name and address of person who

State Registrar

31. Date filed (Month, Day, Year)

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JUL 29

			For State	State of Maryland	•		200	0 0100
			Registrar	<u>.</u>	Certificate of		Reg. No.	3 6466
	Physici /Medio		1. Decedent's Name (First, Middle, Las Audrey E.	# Haacke			e of Death hth Day Yea ULY 25, 2212	3. Time of Death 7 : 20 P M
1	Examin		4a. Facility Name (If not institution, give Saint Joseph			TOWSON		eath timore
	Funeral Director		22, 23, 30,	ex □ M 2□xF 7. Age (In yrs. las.	t birthday) If Under 1 Year Months Days	Hours Min. 8. Date Apr	of Birth Pearl 9. E	Birthplace (State or Foreign Country) aryland
	ne Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Baltim		Perry Hal	1	40-04	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23a or 2	al Dir	10e. Street end Number 9805 Richlyn Dr	ive	10f. Zip Code	128	10g. Citizen of What	S.A.
336	thin 72 hours after death with the Maryland e. a. "natural", or items 23a or 28a-f show Madical Eventher met be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, e Specify:	s or No- tic.) 14. Race - A Black, Wi Specify:	merican Indian, hite, etc. White
21215-0036	H . H	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	durina most of workina	16b. Kind of Busines	•
7	filed withi Hygiene. other than	S		1	Bank Manager		Banking	
yland	or Table	To Be	17. Father's Name (First, Middle, Last) Carl	Haacke		18. Mother's Name (First, Marie		haacke
, Mar	nd 2 sho alth and 27 is m		Donald Seekford-c	" '	19b. Mailing Address (Street 9805 Richly	and Number or Rural Route n Dr., Perry		
Baltimore, Maryland			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	ce of Disposition (Name of netery, crematory or other place Itop Serv Cor		20c. Location - City Towson,	
Balti	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Licen	see William G. Da		k Rd., Towson	Towson Funera , MD 21204	1 Home, Inc.
	Physician /Medical Examiner	L	23a. Part 1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions,	a. PROBABLE SE Due to (or as a consequer CLOSTRIDIUM b.	EPSIS nce of): M DIFFICILE	ng, such as cardiac or respir	atory arrest,	Approximate Interval Between Onset and Death DAYS
8760,0	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examine	death and its conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequent d				
.O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 Ectopic pregnand	cy	23d. Date of Month	delivery Day Year
rds, P.	w requires that been signed should be det	by	Part II. Other significant conditions of ACUTE RENAL F	•	ng in the underlying cause giv	ven in Part I. 23	e. Did tobacco use contribut	e to the cause of death? Probably 4 \(\frac{1}{2} \) Unknown
of Vital Records,		Completed				1)	autopsy prior death Yes 2 □ No 1	e autopsy findings available to completion of cause of 1? 'es 2 \Bo
Σ	slciar certii recto	Be	25. Was case referred to medical examiner?	Hospital:	Ott	26. Place of Death (Checi		
ou of	ng Phy (fter this meral d	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	8b. Time of lnjury 28c. Inju	4 I Nursing Home 5	☐ Residence 6 ☐ Other (Secribe how injury occurred	Бресіту)
Division	il or Atten after deat Director: d in by the	Certification:	3 Suicide 6 Could not be determined		Rural Route Number,			
1	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical C		ysician: To the best of my knowle niner: On the basis of examinatio and manner stated.				
/	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. Licen:	se number	29d. Date signed (M	onth, Day, Year)
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State Registrar

JUL 29 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY HELEN 26, 2009 1:30 A HUDLER 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) FOREST HILL FOREST HILL HEALTH AND REHABILITATION HARFORD Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours 1 ☐ M 2 🔀 F 27, Maryland 1926 Mar. 220-18-5462 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21015 USA 1317 Prospect Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Xo Specify Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative Clerk

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Mary Doyle

20c. Location - City or Town, State

Forest Hill, Maryland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

505 Maitland St., Bel Air, Maryland 21014

Physician /Medical Examiner 1 - For State Registrar

10a. State

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

John Thomas Monahan

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice

19a. Informant's Name/Relationship (Type. Print)

Theresa Rose / Daughter

p Burial 2 ☐ Cremation 3 ☐ Removal from State

Physician

Examiner

Funeral

Director

28a-f show

the

death with

Pages 1 and 2 should be filed within 72 hours after

is marked other than

of Health of item 27 is

permit. Pages 1
Department of H
Important: If itel
any injury or ott

altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Majical Examinating to notified at

/Medical

sician and burial-trans attending physician for use as the burial signed by the a d be detached for funeral director, After this

or Attending Physician: The law requires that the death certificate be executed cate has been signated by page 2 should b death. after death filled in by the 24 hours a Hospitai within 2 the

Division of Vital Records. P.O. Box 68760.

1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final NEUMONIA M disease or condition resulting in death) Due o (or as a consequence of): y ducase JAN WOLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months: 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2.☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner - eath 28c. Injury at Work? 28d. Describe how injury occurred 1 - Natural 5 Pending investigation 1 Yes 2 🗆 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 28-200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT DUNCAN DR. 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ignatius Cath. Chr. 8-3-09

McComas Funeral Home, P.A.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** HABER LENA /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** URMA HIML 7. Age (In yrs. last birthday) W 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/10/1918 Social Security Number Funeral 1 □ M 2 1 F Months Days Hours 092-48-0544 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County id other than "natural", or items 23a or 28a-f show event, the Wedical Evanings must be notified at 1 Yes 2 No Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4204 OLD COURT ROAD 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2 XINo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: WHITE Specify ò 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ont of Health and Mental H
t: If item 27 Is marked oth Be DERMER ROBINSON SARAH SIGMUND ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5237 NW 22ND AVENUE, BOCA RATON, FL SIGMUND HABER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 💢 Removal from State Department of Important: If any injury or 07/28/2009 BETH ISRAEL WOODBRIDGE, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN RD., PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or so a consequence of): Examiner MUNDA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year Day 5 ☐ Other (specify) signed by the a □Yes 2□No 9 Unknown 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an certificate has be rector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To of thours after death.

Funeral Director: After the fetely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

within 24 hou

To the Fune

completely fil

State Registrar

DHMH 17 Rev 1/2001

Medical

determined

4 ☐ Homicide

29b. Signature and title

Name and

29a. Certifier

32 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 25, 2009 5:30 July Joan M. Heidemann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carriage Hill Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Year) Months Days Hours 1 □ M 2 X F 86 February 11, 1923 Illinois 396-16-5468 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 □Yes 2 NNO Directo Maryland | Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event, the Medical Examiner must be reany Injury or other traumatic event. 20815 4603 Langdrum Lane United States by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 24 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Mackenzie Grace Solle ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kris Heidemann / Daughter 720 Elmcroft Blvd., Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition July 29, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 4 Donation 5 Dother (Specify) 2009 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Fune la Service Licensee M01305 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC SARCOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ned by the at e detached fo 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Ho Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Within 24 hours are upcare...

To the Funeral Director. After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

Hospitai

the

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Par, MD 20057124

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, M.D. 101 Molecular Drive, #206, Rockville, Maryland 20850

State Registrar

29a. Certifier

(Check only

31. Date filed (Month, Day, Year) **JUL 29 2009**

09-05855 Darv

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vin Jones		rieas	Stat	e of Mary	land / I	Depar	tment of	Health	and	Menta	Нус	jiene	Ū			
	F	- For State legistrar				Certi	ificate of	Death			- [0	Date of D	Reg. No.	2		e of Death
Physicia dical Examii	111/	1. Decedent's Name (Fir	rst, Middle,L	.ast)	Larr	cell		Jo	nes	3		Month July 26,	Dav	Year	1	04 hrs
aroar Exam.		4a. Facility Name (if not	institution,	give street and			4	b. City, Tow		ocation of I				c. County of D	Death	
		University Hosp			1			Baltimo		If Under 2	2/Hrs	8 Date of	Birth/MM	VDD/YYYY) ⁹	. Birthplace	(State or
Funeral Director	1	5. Social Security Numb	1	Sex			st birthday)	Months	Days	Hours	Min.	05	12	90	oreign Country)	MD
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with the ms 23a be not		11. Marital Status		12. Was I	Decedent E	ver in U.S	3. 13. Wa	s Decedent es, specify (of Hispa	anic Origir Mexican, F	n? (Spe Puerto R	cify Yes or	No-	14. Race - A White, e	American Inc	lian, Black,
r death or ite	Funeral	1 X Never Married		1 Ye	2	X No		Yes 2						Specify:	Blac	k
215-0036 be filed within 72 hours after that Hygiene. *red other than "natural", ent, the Medical Examiner.	à	3 Widowed 15. Decedent's Educa		or Dates:		oleted)	16a. Deceder		ccupatio	n (Give ki	nd of wo	rk done	16b.	. Kind of Busin	ness/Industr	,
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c eveut, the Medica	Be C	Phillip 3	Jones	3								Jon				
21 should I nd Mer is mar	Ţ	19a. Informant's Name/			ner		19b. Mailin 3918	g Address	(Street	and Numb	er or Ru Roa	ural Route d , B	Number, alt	City or Town,	State, Zip C	2 1 229
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposi	ition				Place of Dispos	sition (Name				Date		c. Location - 0		
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Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other it		4 Donation 5 21. Signature of Funera	al Service L	icensee	2		22.1 M a	Name and A	ddress	of Facility	t					
		23a. Part L'Enter the d	isease or c	omplications th	at caused t	the death.	1/1/3	$\Omega \Omega W$	aha.	sh A	Ve.	Bal respirator	tim y arrest, s	ore, shock, or hear	t Apr	215 proximate Interval
Physician /Medical		failure. List only of Immediate Cause (Fin.	one cause o	n each line. a. Multiple											Be	tween Onset and Death
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tal Records, P.O. Box 68760, cian: The law requires that the death certificate be certificate has been signed by the attending physici ector, page 2 should be detached for use as the buni	Physician/Me	IF FEMALE: 23b. Was decedent pre past 12 months?	egnant in the	3 1 □ L	es, outcon		2 F	etal death	3	Ectopic	pregna	ncy		Month	Day	Year
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n of Vital ling Physician: After this certif funeral director,	n: T	27. Manner of Death	1110	28a.	Date of Injudently Day 1	ury Year)	28b. Time of 2221 hrs	f Injury 2		iry at Work	-	28d. Des Subject		v injury occurr	ed	
ivision or Attendi after death. Director:	atio	1 Natural 2 Accident	5 Pend Inves	tigation			nome, farm, st	eet factory		Yes 2.		28f. Loca	tion (Stre	eet and Numb	er or Rural F	Route Number, City
V. Vi	1 =	3 Suicide € 4 ✔ Homicide		not be	ecify) Lo			ect, factory	, omce i	panding, o		200 N C	own, State	e) Street, Balti	more, MD	
Hospi 24 hou Funer		29a. Certifier	ertifying Ph	nysician: To th	e best of m	ny knowled	dge, death occ	curred at the	time, d	ate and pl	ace, and	d due to the	e cause(s	s) and manner	r as stated.	1150(5)
To the Hos within 24 h To the Fur completely	Medical				asis of exa ner stated.	mination a	and/or investig			se number		at the time		29d. Date sign		
	Σ	29b. Signature and tit	1 -	- Inn				250		M.E.			1	July 27, 20	·	
		30. Name and address	s of person		cause of	death (Iter	m 23a)									
LV		Donna M. Vir	ncenti, M	D Assista	nt Medi	cal Exa	miner 1	11 Penn		t, Baltim	ore, N	/ID 2120	1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ones 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number Sex 1☐M 2☐F **Funeral** Min. Year) 62 Months Days Hours Yrs. 214-44-6583 10 12 Director 46 NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Experience as be rectilled at MD N/A Baltimore 1X Wes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21231 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 330 Ballou Ct 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes XXNo If Yes, Give Year or Dates: Specify Completed by Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Penn Lumber Co. Truck Driver 10th N/A permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any liginy or other traumatic event, sone. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claudie Jones Denise Lee West ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Geraldine Morgan-friend 330 Ballou Ct. Baltimore, MD Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 15€Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Western Star Cem. 7/31/2009 Baltimore Co.

22. Name and Address of Facility MARCH FUNERAL HOME-EAST 21. Signature of Funeral Service Licensee la 1101 E. North Avenue Baltimore, MD 21202 one 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a co Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 - No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2ER/Outpatient 3 DOA Certification: To 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUL 29

30. Name and addres

32. Registrar's Signature

leva J. Jarle

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** REGINA CATHERINE JORDAN 05:29AM 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Joseph Medical Towson Baltimore Saint Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 14,1925 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 □ M 2 🖸 F Maryland 83 214-20-6188 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County show Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be nettled as once. Baltimore County Baltimore 1 ☐ Yes X2X No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 21236 212 Leslie AVenue Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 → No White Specify: þ XX Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n 8th grade (0-12) Housekeeping-Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Mueller William Nigrin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 31 Leslie Avenue Baltimore, Md. 21236 John H. Jordan, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a Method of Disposition Pages 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 7-31-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sovice Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as a consecuence of) Examiner burial-tran and Due to (or as a consequence of) attending physiclan for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached fi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an pate has l autopsy perform 2 certificate 1 ☐ Yes or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? 1☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident Time of 28d. Describe how injury occurred 28b. 28c. Injury at Work? 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide the Hospital within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State Registrar (Check only one)

29b. Signature and title of certifier

HIOSROW TABASSI.
Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

P.O.

of Vital Records,

Division

29c. License number

D46356

DRIVE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State State Registrar	of Maryland		rtment of F tificate of I			giene Reg. No. 201)9	24228
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth	rear	3. Time of Death
	Physicia /Medic		Omer Steven Jennings,	Jr.				July 2	28, ^{Day} 2009		3:30 AM
way.	Examin		4a. Facility Name (If not institution, give street and r				Location of Death	1	4c. County of	f Death	
angle .			St. Elizabeth Nursing 5. Social Security Number 6. Sex	Home 7. Age (In yrs. Ia	ot hirthday)	If Under 1 Year	imore If Under 24 Hrs.	8. Date of Birtl	h !	9. Birthol	ace (State or Foreign
	Funeral Director		218-26-3609 6. Sex 1 M 2 □ F		Yrs.	Months Days	Hours Min.	Dec. 18	v. Year)	Coun	yland
1			Usual Residence of Decedent	1 1 9				200.	,		
	ryland thow		10a. State 10b. County	10c. City,	, Town or Lo	cation				10	od. Inside City Limits 1 ☐ Yes 2 ☑ No
	e Ma 8a-f s	cto	Maryland Baltimore	На	1etho:				10g. Citizen of Wh	at Coun	
	or 2	Dire	10e. Street and Number 961 Regina Drive			10f. Zip Code 2122	7		USA	iai Couri	u y r
	ns 23	Funeral Director		ecedent Ever in U.S	3. 13. V	Vas Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Medical Exercises must be notified at once.	by Fun	Armed	Forces? s 2 □ No Give		fÝes, specify Cuba I □Yes 2. X No	an, Mexican, Puerto Specify:	o Rican, etc.)	Black Specify:	White, e	
ခို	2 hour	led l	15. Decedent's Education		16a. Deced	ient's Usual Occup	pation	10	16b. Kind of Bus	iness/Inc	lustry
215	hin 72 9. an "ne Media	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College	d) (1-4or 5+)			during most of wor. d)	King			
21	ed with	Con	12	` '	Owne	r/Operato			Restau		
Baltimore, Maryland 21215-0036	d be file ental Hy ked oth c eveni	To Be	17. Father's Name (First, Middle, Last) Omer Steven Jennings, S	r.			18. Mother's Nan Gretta M		Maiden Surname umaw)	
ary	shoul and Mi s marl umati	Ě	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town, S	State, Zip	Code)
Ĕ	and 2 salth a n 27 ls		Omer Jennings, III	Son			ll Road;				
ore	es 1 a of He of He if item		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal fro	m State 20b. Pla	ace of Dispo emetery, cren	sition (Name of natory or other plac		Date	20c. Location - C	•	
Ĕ	Pag tment tant; I		Donation 5 ☐ Other (Specify)		odlawn	Cemetery	y 8/3/	2009	Woodlawn	, Ma	ryland
Ball	ermit Depar mpor Iny in		21 Signature of Funeral Service Licensee	undinit	²²	Name and Addre	ome of C	atonsvil	le, Inc.	nwau	WILZKE
	TO = 40		200 Party Faster the disease are complications the	LONG the death	Do not ent	630 Edmo	ndson Av	enue; Ca	rest	e, M	Approximate Interval Between
		8 3	23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of immediate Cause (Final	n each line.	. Do not ent	TH OT	11/8	o or roophatory a		9	interval Between Onset and Death
-	Physician /Medical		disease or condition	to (or as a consequ	Representation	10 1H	CIVO			-	
	Examiner			.o (or as a consequ	ierioo ory.						
	D #	ner	Sequentially list conditions, if any, leading to immediate Cause, Enter Linderwing	to (or as a consequ	ence of):						
*	ecuter nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
Ö,	icate be executed physician and s the burial-transit		resulting in death) Last Due	to (or as a consequ	ience of):						
8760,	physic physic the b	dical	d								
× 6	leath certifi attending for use as	/Me		outcome of pregnar					23d. Date	of deliv	ery
P.O. Box	death e atter	iciar	in the past 12 months?	ve birth 2 - Fetal regnant at time of de		□ Ectopic pregnand □ Other (s <i>pecify</i>) _	cy		Mor	nth	Day Year
O.	t the by the	hys	9 ☐ Unknown	nknown							
S,	ires that the de signed by the a I be detached t	by Physician/Me	Part II. Other significant conditions contributing to			-	ven in Part I.				he cause of death? cably 4 ☐ Unknown
o G	w require been si should b		COPP LO	NG 1	MAS	>		19			
ě	e law r has bu je 2 sh	Completed						24a. Was	psy p	vere auto rior to co eath?	ppsy findings available impletion of cause of
E H	: The cate l	Con						1 □ Yes	2000 1	□Yes	2 🗆 No
₹ K	sician certif rector	Be	25. Was case referred to medical examiner? Hospital:			Otl	hor: \	ath (Check only o		(0	6.1
ō	Phys rr this aral di	1. To	27, Manner of Deat 28a. Da	☐ Inpatient 2☐	28b. Time o	f 28c. Inju	iry at		how injury occurre		<u></u>
on	th. : Afte	tion	Natural 5 Pending (N 2 Accident investigation	fonth, Day, Year)	Injury	M 1 🗆	rk?]Yes 2 ∐ No				
Division of Vital Records,	I or Attending Physician: The I after death. Director: After this certificate ha I in by the funeral director, page i	Certification: To		ace of Injury - At ho illding, etc. (Specify	ome, farm, str	reet, factory, office		28f. Location (City or To	Street and Number	er or Run	al Route Number,
Ξ	ital or A							1			
-1	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the and many one)	the best of my know the basis of examination	wiedge, deat tion and/or in	n occurred at the f nvestigation, in my	opinion, death occ	e, and due to the urred at the time	date and place, a	and due t	o the cause(s)
1	To the within 2 To the comple	Mec	29b. Signature and title of certifier	A		29c. Licen	se number		29d. Date signed	(Month,	Day, Year)
	⊢≶⊨ŏ		DR Ferrander A	Hendy	1-M	0 05	50303		7-	28	-09
			30. Name and address of person who completed o	ause of death (Item	23a) (Type,	Print)			31	- 0	
			Rodolto Fernandez	= 516 N	1 Roll	1x Rd	Ste 205	(ethe	1 eliver	12:	82512
	Sta Regist		31. Date filed (Month, Day, Year) 32	2. Registraris Signa	art						

DHMH 17 Rev 1/2001

D I		1 - For State Registrar 1. Decedent's Name (First, Middle, La	st)	С	ertificate of	Death	2. Date of Death	eg. No. 2005 h Day Year	3. Time of Death
Physic /Medi Examii	cal	4a. Facility Name (If not institution, given Northwest Hos	Tohnson re street and number)		4b. City, Town, o	r Location of Death	July	4c. County of Deat Baltimor	
Funeral Director		5. Social Security Number 6. S 214-64-0051 Usual Residence of Decedent	Sex 7. Agr	e (In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt Co	hplace (State or Foreign untry) M)
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ny or other traumatic event, the "heatest Examiner must be natified at	ector	10a. State 10b. County M D Baltimo	re	10c. City, Town or Randa	Location Listom 10f. Zip Code		11	0g. Citizen of What Co	10d. Inside City Limits 1 □ Yes 2 □ No
s 23a or	Funeral Director	8805 Stahmie Roa		5 t- 110 L-	21	133		USA 14. Race - Ame	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mactical Examinat must be notified at one.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 \(\text{Yes} \) 2 \(\text{N} \) If Yes, Give Year or Dates:	No	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Specify:		Black, White	e, etc. ack
d within 72 h giene. Ir than "natu	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	(G	ecedent's Usual Occu ive kind of work done e. DO NOT use retire	oation during most of work d)	ing	16b. Kind of Business/	·
ild be filed fental Hyg rked othe fic event,	To Be C	17. Father's Name (First, Middle, Last William Johnson)			18. Mother's Name		Maiden Surname)	
nd 2 shou alth and M 27 is mar ir traumat		19a. Informant's Name/Relationship	,		ailing Address <i>(Street</i>			; City or Town, State, 2	Zip Code)
Pages 1 a ment of He ant: If item ury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 L 4 Donation 5 Other (Speci	Removal from State	20b. Place of Dicemetery, of	sposition (Name of crematory or other pla	ce) : 8/5/	Date '	20c. Location - City or Baltimore	•
permit. Departi		21. Signature of Funcial Service Lice	nsee /		22. Name and Address	Wyl		Himes Of Bal	
Physician /Medical Examiner	Examiner	23a art1. Enter the disease, or hock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Complete for as b. Complete for as c.			ng, such as cardiac		est,	Approximate Interval Between Onset and Death
rificate be executed og physician and as the burial-transit	Aedical Ex	_ = = .	d.	a consequence on.					
ath cel attendii for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of de Month	livery Day Year
equires that en signed b	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying cause gi	ven in Part I.		bacco use contribute to es 2 ☐ No 3 ☐ P	
:: The law re icate has be ; page 2 sho	Completed						24a. Was a autops perforr 1 □ Yes	sy prior to med? death?	utopsy findings available completion of cause of
hyslciar his certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital; 1 ☐ Inpatie	ent 2 ER/Outpa	Illenii 3 🗆 DOA		ome 5 Reside	ence 6 ☐ Other (Spe	ecify)
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification:	27. Manner of Death 1	e 28e. Place of Ini	y, Year) Inju	ry Wo	ry at rk?]Yes 2 □ No		ow injury occurred treet and Number or R n, State)	'ural Route Number,
Hospital 24 hours a Funeral I etely filled	edical Ce			of examination and/o				cause(s) and manner a date and place, and du	
To the within To the comple	Med	29b. Signature and title of certification	michael de		29c. Licen		2	29d. Date signed (Mon.	Ì
51		30. Name and address of person who Dr. Michael D	ewit Nort	thwest h	lospital	5401 01	d Court	Randalls Road	21133
St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 29 2009	32. Registr	ar's Signature	Kel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 4:00 PM July 25 2009 FLORENCE ANN JONES /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner DEKAM KWERSI If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 🞾 F Yrs. Director 219-38-2126 Nov. 16. 1940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 580 Renee Drive Apt. B 21085 USA Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify. ģ 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If Item 27 Is marked ott any Injury or other traumatic ever one. Charles Peyton Fawcett Lillian (nmn) Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Baker / Niece <u>580 Renee Dr., Joppa, MD 21085</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Hilltop Service Corp. 7-28-09 Towson, Maryland 21. Signature funeral Service Licenses McComas Funeral Home, P.A. Me 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic charge tive primms **Physician** EWD STREE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initiourate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hypothymodum 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed physician and sthe burial-tran Division or Vital Records, P.O. Box 68760, attending p as nse ģ has or Attending Physician: within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

filed within 72 hours after death with the Maryland

21215-0036

Maryland

Baltimore,

2 should be fi

ral", or Items 23a or 28a-f show Examiner must be notified at

"natural", or

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Mn

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

neclima

32. Registrar's Signature

AAVID

2009

29c. License number

29d. Date signed (Month, Day, Year)

615 Mac Wait No And Aur MM 21014

2423

		-	State of Maryland / Department of State of Registrar State of Maryland / Department of Certificate of Certific			giene Reg. No.	
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month July	Day Year 27, 20	3. Time of Death 7:32A M
-	/Medic Examin	al	Irvin P. Keplinger 4a. Facility Name (If not institution, give street and number) 4b. City, Town	, or Location of Death	July	4c. County of De	0 9
	Examili		Gilchrist Hospice Towso	on		Balti	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes 218-32-9008 Tym 2 F 73 Yrs.		8. Date of Birtl (Month_Da) 12/15/	1935 9. B	irthplace (State or Foreign Country) MID
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary a-f sh	ctor	MD Baltimore Phoenix				1 □Yes 2 No
	th with the 23a or 28: list be not	Funeral Director	10e. Street and Number 13519 Jarrettsville Pike 211			10g. Citizen of What C USA	Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its Medical Evicinal nations and injury or other traumatic event, its Medical Evicinal nations.	by Funer	11. Marital Status 1 Never Married 3 Warried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 No If Yes, Sive Year or Dates?	of Hispanic Origin? (Sp uban, Mexican, Puerto No <i>Specify</i> :	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: W	
altimore, Maryland 21215-0036	vithin 72 ho ene. than "natur or Wedical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Oc (Give kind of work do life. Do NOT use ret Mechanic	cupation ne during most of work ired)	ing	16b. Kind of Busines Automot	
0	filed v Hygie other 1	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle,	Maiden Surname)	
ılan	Vental Vental rked c	To B	Joseph A. Keplinger	Mary P			
, Mary	and 2 shorestith and Programs 27 is mager trauma		19a. Informant's Name/Relationship (Type. Print) Deborah Niels/Daughter 19b. Mailing Address (Street 13519 Jarre	ettsville	Pike	Phoenix,	MD 21131
more	Pages 1 annent of He ant: If Item ary or oth		20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other) Chesapeake Cre	em. 20	09	Beltsvil	le, MD
Balti	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee WOVY3 22. Name and Ad 8717 G1	dress of FacilIIICAF ceen Past	A/Step ures D	hen D.Lo r. Balto	hrmann P.A. , MD 21286
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart fallure. List only one cause on each line.	dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
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O. Box	ath ce	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify graph)			23d. Date of Month	delivery Day Year
rds, P.	quires that the de n signed by the s uld be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did t	An	e to the cause of death? Probably 4 Unknown
Division of Vital Records,	The law requir ate has been s page 2 should	Completed			24a. Was autoj perfo 1 ∐Yes	psv prior	autopsy findings available to completion of cause of ? 'es 2 \Boxed No
Vita	iclan: The certificate ector, pag	Be (25. Was case referred to medical examiner?	26. Place of Dea			1.050%
of	Phys er this eral dir	۲: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c.	4 ☐ Nursing H Injury at Work?	ome 5 ☐ Resi 28d. Describe	dence 6 Other (S	specify) WOSPICE
ion	ath. ath. r: Afte	atio	2 Accident investigation	work? 1 □Yes 2 □No			
Divis	al or Atte s after de il Directo ed in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)	ce	28f, Location (City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital or Attending Physiclan: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in and manner stated.	ne time, date and place my opinion, death occu	e, and due to the irred at the time,	e cause(s) and manne , date and place, and o	r as stated. due to the cause(s)
	To the within	M	29b. Signature and title of certifier	sense number 58303		July 27	onth, Day, Year)
_	Ox,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Charles	STJ	DNSON!	MD
	Sta Registi		31. Date filed (Month, Day, Year) 32. Pegistrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 24232 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 24,2009 **Physician** Robert J. Kaufmann, Jr. 1:45P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Timonium <u>Baltimore</u> | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months Days Hours Min. | 0ctober 26, 1956 Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ▼ M 2 □ F Director <u> 218-68-6249</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be rollined at 1 ☐ Yes 2 👿 No **Funeral Director** Md. Balto. Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 US 13 Brook Farm Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Manager Printing Company 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any lininy or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Robert J. Kaufmann, Sr. Mirian Moberly ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3901 Darleigh Rd. 3A Nottingham, Md. 21236 Mirian Kaufmann Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-27-2009 Bayview Crematory Baltimore City, Md. 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee terries 9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE RENAL DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed be detached for use as the burial-trar Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2 □ No signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 1 □ Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) X Nurse Practitioner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

2009

KAUFMANN

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 2 9 2000

Lucus A. Bark

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES, CRNP

2300 DULANEY VALLEY RD.

2009

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Ho MUN Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) Sex Funeral Days Hours Min. 1**⊠** M 2□ F 219-50-6969 62 NC 3-1-47 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Extended must be notified at N/A Baltimore 1 ☐ Yes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA 3952 W. Northern PKwy-Apt. B3 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status within 72 hours after 1 Never Married 2 Married African Maryland 21215-0036 1 □Yes 2 No Specify: þ Mmerican 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Self Elementary/Secondary (0-12) College (1-4or 5+) Handyman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H f item 27 is marked oth Sallie Batts Robert London 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 3952 W. Northern Pkwy-Apt.B3,Balt.,MD 21215 Roxanne London/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory 7/30/09 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHari P. Close F.Svs, PA 21. Signature of Funeral Service License 5126 Belair Rd, Balt., MD 21206-5105 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, complications that caused the shock, or heart failure. List only one care e on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of): burial-transi Exam and Due to (or as a consequence of): Box 68760 attending physiclan for use as the buria certificate be Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 XNO 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2√□No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Westerd 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 2 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident filled in by the 6 ☐ Could not be 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

′) √ Sta

State 31. Date filed (Month) Day, Year)

Registrar JJL 2 9 2069

Name and address of purion who complete

32 Registrar's Signatus back

cause of leat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 27 ^D2009 **Physician** Willie Andrew Lynch 9:25 a M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore N/A 401 E. 25th St.-Apt. 8P Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F 48 215-86-4943 5/25/61 NC **Director** Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 Yes 2 □ No N/A MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 USA 401 E. 25th St.- Apt. 8P Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status African Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specifymerican 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Construction Elementary/Secondary (0-12) College (1-4or 5+) Laborer 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Magnora Richardson Leslie Lynch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Magnora R. Lynch/Mother 2605 Spelman Rd-Apt.C1, Balt., MD 21225 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 □ Cremation 3 □ Removal from State Walters Chapel Cem 8/2/09 Hollister, NC 4 ☐ Donation _ 5 ☐ Other (Specify) 22. Name and Address of FacilitHari P. Close F.Svs., PA neral Pervice Lio 21. Signature of F 5126 Belair Rd,Balt.,MD 21206-5105 Approximate Interval Between Onset and Death 23a. Part 1 Firer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cirrhosis. Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Alcoholism. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and ned for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the ad be detached for ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D28266. M.D. 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) V 5010. YORK Road, Ballo, MD. 21212. AYELWIN. M.D. 31. Date filed (Month, Day, Year) State JUL 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ?

		1	1- For Amend Item 26 per dr., g893,07/29 Registrar Certif	ficate of Death	Reg	1. No.
	Physicis	_	1. Decedent's Name (First, Middle, Last)		2. Date of Death July 19 20	3. Time of Death 12:05 P M
4	Physicia /Medic	al	Irene D. Licato	b. City, Town, or Location of Death		4c. County of Death
	Examin	er	4a. Facility Name (If not institution, give street and number) 5626 Knell Avenue	Baltimore City		Baltimore City
-4-21	Funeral Director			Months Days Hours Min.	8. Date of Birth (Month, Day, November 1	9. Birthplace (State or Foreign Country) 5 1929 Mary Land
	p		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	tion		10d. Inside City Limits
	Maryla f sho	tor	Maryland Baltimore City Baltimore			1 X ☐Yes 2☐No
	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Exambrat must be profilled at	Funeral Director	10e. Street and Number 5626 Knell Avenue	10f. Zip Code 21206	100	g. Citizen of What Country? USA
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was Armed Forces?	as Decedent of Hispanic Origin? (Spress, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9800	ours after ral", or ite Examina		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 ☐ No If Yes, Give 1 ☐ Year or Dates:	∃Yes 2 🖾 No Specify:		Specify: White
15-0	יו 72 h "natu	Completed by	(Specify only highest grade completed) (Give kir.	nt's Usual Occupation nd of work done during most of worl O NOT use retired)		6b. Kind of Business/Industry
212	l within giene. r than "	dmo	Elementary/Secondary (0-12) College (1-4or 5+) Housewill	fe		ousekeeping-Own Home
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination and the notified at	To Be C	17. Father's Name (First, Middle, Last) Francis Malinowski	18. Mother's Nam Hedwig G	ne (First, Middle, Ma rela	aiden Surname)
Mary	1 and 2 should Health and Mer em 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Anthony Licato (Son) 19b. Malling 6537 Con	Address (Street and Number or Ru rkley Road Baltimore	ral Route Number, ,Maryland 2	City or Town, State, Zip Code)
more,	Pages 1 and ont of Hering It item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposit cemetery, crema Parkwood Ceme	ion (Name of tory or other place) etery July 22 2009		Oc. Location - City or Town, State
Baltii	permit. Page Department of Important: If any injury or once.		21. Propature of Funeral Service Licensee	Name and Address of Facility Sann Funeral Home In 1 Belair Road baltin		and 21236
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arre	st, Approximate Interval Between
1	Physician	r ii	Immediate Cause (Final disease or condition	TOS15		Onset and Death
d	/Medical Examiner		resulting in death) Due to (or as a consequence of):	ENIC CAR	CIN O	ru A Lycay
		Je.	Bequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1010		
	ecuted and transit	Examiner	triat initiated events			
60,	be exician a					
68760,	rificate be executed ng physician and as the burial-transit	Medical	d.			
O. Box	the Hospital or Attending Physician: The law requires that the death certificate be executed bin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
S, P.	es that tigned by			derlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death? s 2 □ No 3 □ Probably 4 □ Unknown
of Vital Records,	w requires t been signe should be o	Completed by	Attaced a 40 Cardia 1/80	calar)	24a. Was an	
Rec	sician: The law certificate has briector, page 2 s	duc	of Zanda		autopsy perform	prior to completion of cause of
ta	an: T	a	25. Was case referred to medical	26. Place of De	1 □ Yes 2 ath (Check only one	
of V	Physical this ce	To B	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			nce 6 Other (Specify)
o uc	ding Phy h. After thi funeral			28c. Injury af Work? M 1 ⊡Yes 2 □ No	28d. Describe ho	w injury occurred
Division	or Attendi after death. Director: A	Certification:	'2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		28f. Location (Str City or Town	reet and Number or Rural Route Number, , State)
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Co		occurred at the time, date and place estigation, in my opinion, death occ	e, and due to the caurred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of conflict	29c. License number	6	9d. Date signed (<i>Month, Day, Year</i>) 7/21/2009
	-		30. Name and address of person who completed cause of death (ttem 23a) (Type, P	Modic- OC.	ter 1	Baltines MD 2122
	5		30. Name and address of person who completed cause of death (ttem 23a) (Type, P Sex) 31. Date filed (Month, Day, Year) 32. Registrar's Signature and Sex (Month, Day, Year)	1		5 7 100 4 112 422/
	Regist	ate rar	JUL 29 2009 Devent S. Jake			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 26, Day 2009 2:02P Ju₁y Joseph Lucas 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Oliver Beach Balto. 7108 Oliver Wood Rd. 8. Date of Birth (Month, Day, Year) mber 2,1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **X** M 2□ F Country) Pennsylvania Months Days 84 211-12-8106 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2√ No Md. Balto. Oliver Beach 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 USA 7108 Oliver Wood Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No If Yes, Give White 1 □ Yes 🐰 □ No 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Coca Cola Supervisor 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sophie Picoccolo John Lucas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Spouse 7108 Oliver Wood Rd. Oliver Beach, Md. 21220 Mary Lucas 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Md. 7-29-2009 Moreland Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 97<u>05 Belair Rd.</u> Nottingham, 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Grant day list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) Month Day Year t∐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

Important: If item 27 is marke any injury or other traumatic

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

ed other than "natural", or items 23a or 28a-f show event, the Medical Exercitor must be notified at

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

Examiner attending physician and for use as the burial-tran signed by the a Be Certification: To

Physician/Medical ð Completed

completely filled in by the

1 ☐Yes 2 ☑No

1 ☐Yes 2 ☐No

(Specify)

o, was case relened to medical		26. Flace of Death (Check Only Che)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐]Other
7. Manner of Death 1 ☑ Natural 5 ☐ Pending		Firme of njury at Work? 28d. Describe how injury of	ccurre

investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

29a, Certifier

(Check only one)

Medical

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

13AL7 cmp 2122

b. Signature and title of certifier	29c. License number
	D 00 14

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 RON 223 32. Registrar's Signature

31. Date filed (Month, Day, Year)

09-05830	
William Logar	n

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day July 25, 2009 1314 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Upper Chesapeake Medical Center **Bel Air** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign 5, Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Country Months Director March Carolina South 32 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Phygiene and I fitted that and Mental Phygiene and I fitted 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Maryland Director 10g. Citizen of What 10e. Street and Number 14 Race - American Indian, Black Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. 12. Was Decedent Ever in U-S 11 Marital Status White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes Yes 2 No specify: 3 Widowed Divorced If Yes, Give Yea 9 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) abores Baltimore, MD 21215-0036 unknown 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Wells Kate UNKNOW Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ empler War 20b. Place of Disposition (Name of cemetery crematory or other place 2 Cremation 3 Removal from State Marylan Department of Important: I Western Other Specify Donation 5 21. Signature of Funeral Service Licensee Appro imate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or **Physician** Between Onset and failure. List only one cause on each line Medical a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED UNPENDED ned by the attending physician detached for use as the burial The faw requires that the death certificate be Box 68760, 23d. Date of deliver IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Dav Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. icate has been signed by page 2 should be detach ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' Yes 2 V No Νo certificate To the Hospital or Attending Physician: 'within 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other₄ Hospital: 1 Nursing Home 5 Residence 6 DOA Inpatient 2 Y ER/Outpatient this ۵ 1 🗸 Yes No 28d. Describe how injury occurred To the Funeral Director: After t completely filled in by the funeral 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Certification: 1 V Natural Yes 2 No Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 V Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 27, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD. 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	_	Registrar 1. Decedent's Name (First, Middle,	l act)			incate or	Death	2.	Date of Death	g. No.	1117	3. Time of Death
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/Medio Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Location of		July	_	y of Death	
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Funeral			Sex 1 □ M 2X F	7. Age (In yrs.		If Under 1 Year Months Days		Min.	Date of Birth (Month, Day,	Year)	Coun	
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and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					1	0d. Inside City Limits
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the 7.283	Director	10e. Street and Number				10f. Zip Code			10	0g. Citizen of	What Coun	itry?
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deat	Funeral	11. Marital Status	12. Was Dec Armed F	cedent Ever in U	J.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Or ban, Mexicar	igin? (Specit	fy Yes or No- can, etc.)		ace - Americ ack, White,	
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in in in in in in in in in in in in in i		XXWidowed 4 ☐ Divorced 15. Decedent's	Year or I	Dates:	16a, Dece	dent's Usual Occu	pation	-		 16b. Kind of E		
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or of or		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	B ☐ Removal from	n State	cemetery, cre	matory or other pl n Cemete		7/25/			•	Maryland
partition is, interpretable and 2 in 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Madical Exprinent is used by notified at once.	li e	4 □ Donation 5 □ Other (Sp		0		O Name and Add	ease of Essili	ita		- 3715		
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Dhusisian	6 5	shock, or hear tailare. List o	nly one cause on	each line.							1	Onset and Death
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and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a conse	quanca of:				 -			
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Phys rthis ral dir	2	1 Yes 2 XNo 27. Manner of Death	28a. Dai	Inpatient 2 [te of Injury	28b. Time	ent 3 🗆 DOA	4 L N		e 5 X Resid			ify)
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TO the Hospital or Attendin within 24 hours after death. To the Funeral Director: After completely filled in by the fun		(Check only 2 Medical I	xaminer: On the	basis of exami	nowledge, dea	ath occurred at the nvestigation, in m	time, date a	and place, a eath occurre	nd due to the d at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
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		30. Name and address of person value Paul Schwartz		3512 Ne			ltimo	re, Ma	aryland	2121	.8	
St	ate	31. Date filed (Month, Day, Year)	32.	Registrar's 9 g								
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,\overline{0}\,0\,9$ Certificate of Death 3. Time of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle Last) Physician /Medical nstitution, give or Location of Death 4a. Facility Name / Examiner If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day) Social Security N nbe **Funeral** Days Months Min 1 ☐ M 2 🔀 Director Usual Re 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Ob. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any Injury or other traumatic event, the Wordent Exercited from the profitted at once. 28a-f show 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10g. Citizen of What Couptry? 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital State Black, White peto □Yes 2 140 1 Never Married 2 Married 2 100 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent' sual Occupation (Give kin of work done during most me. pc OT use retired) 16b. Kind of Justness/Industry Elementary/%e • • ry (0-12) College (1-4or 5+) 5 Sew 18. Mother's Name (First, Middle, Maiden Be ပ mant's Name/Relations p (Type 19b. Mailing Addre Location - City or Town, State 20b. Place of Disposition cemetery, crematory Method of Disposition 1 Byrial 2 ☐ Cremation 3 Removal from State 4 Donation 5 DOther (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one caus. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Year Month Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Ves 2 Mo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1X Natural 1 □Yes 2 □ No n 24 hours after death.

Reference of prector: A setely filled in by the filled in the 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0040904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1209A Marda Lane, Annapolis, MD 21403 Nancy D. Rivera-King MD. 62. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24240 State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Dav Vear Month **Physician** P M 27, 1910 TULY 2009 FRANKIE MOORE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** RANDALISTOWA BALTIMORE HOSPITAL NORTH WEST If Under 1 Year | If Under 24 Hrs. 9. Birthplace Country) 8. Date of Birth (Month, Day, (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min 1 □ M 2 ▼ F NC Director 85 224-34-0374 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ed other than "natural", or items 23a or 28a-f shove event, the Medical Empires must be rediffed at 1 XYes 2 ☐ No Director Baltimore MD NA 10g. Citizen of What Country? 10e, Street and Number s 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 3 U.S.A. 21207 3613 Sylvan Drive Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. I □Yes 2 No f Yes, Give X 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 2 ¥□ Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Housewife 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u> Maggie Hawkins</u> Arthur Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3613 Sylvan Drive, Baltimore, Md 21207 Kay Moore Abrams-Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot urial 2 Cremation 3 Removal from State Woodlawn 8/1/09 Woodlawn, Md onation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West ure of Funeral Service Licensee 21. Sign Baltimore, Md 21215 4300 Wabash Ave, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Ven truc **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1/20thing Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐Yes 2 No cate has been signed by the page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy 1 ☐ Yes 2 🗷 🗴 o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28b Time of 28c. Injury at Work?

Hospital or Attending Physician: The law requires that the death certificate be execufed funeral director, After n 24 hours after death.

e Funeral Director: Af þ within 24 hor To the Fune completely fi

Certification: To Medical

State

Registrar

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

X414

D0059736

5401

OLD

HOSPITAL

COURT ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wi-tron Fitzpatrick Deborah

31. Date filed (Month, Day, Year) 29 2009

NORTHWEST 32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item of Maryland / Bepartment of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death Date Month 27 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 8:15a.M. McDade Nathaniel Jesse 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) NA Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 36 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1**№** M 2□ F 72 Tennessee 412-56-4148 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 ☐ No N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21214 USA 5303 Walther Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Maryes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 400 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor of Philosophy Morgan State 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jones Mame McDade Nathaniel Jesse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5609 Winthrope Avenue Baltimore, MD 21214 19a. Informant's Name/Relationship (Type. Print) Jesse N. McDade-son 20b. Place of Disposition (Name of cemetery, crematory or other place).
Garrison Forest 20c. Location - City or Town, State Date 20a. Method of Disposition MD Owings Mills Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/3/2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1101 E. North Avenue Baltimore MD land MD 21202 Baltimore, a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lus Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably > ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 □ No nem a 1 ☐ Yes 25. Was case eferred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 2 100 6 Stother (Specify) INCO 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It is refulled. Evanting once. Baltimore, Maryland 21215-0036 - Physician /Medical **Examiner** 68760, Division of Vital Records, To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely

inc Dade

After this certific funeral director.

Physician/Medical

Completed

Certification: To

Physician

/Medical

Examiner

Director

Completed

Be

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MD

Funeral

Director

State Registrar MI)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23-1 Type, Print)

Relived Street 419 1V25t

31. Date liled (Month, Day, Year)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#19b, per INF, G894, 873709, WS
State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 26, Peter Murray 2009 2:35 Α Ju₁y /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 13, 1920 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 89 202-42-1220 England Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it a No item Eva of natural be required at any injury or other traumatic event, it a No item Eva of natural be required at any injury or other traumatic event, it a No item Eva of natural be required. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Montgomery Village 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20308 Canby Court 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: White ò 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief Scientist Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Murray Ann Hamstead မ 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jane Angela Weston / Daughter 210 Glen Oak Drive, East Amhurst, New York 14051 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 6, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 21. Signature of Fune Service License 22. Name and Address of Facility. Robert A. Pumphrey Funeral Home/Rockville, Inc. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumoni **Physician** /Medical Due to (o as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part !. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 🔼 No 1 □Yes Be 25. Was case referred to medical director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending after death. 1 □Yes 2 □No investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled it 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) 29c. License number Completed cause of death (Item 23a) (Type, Pfint)

1 29d. Date signed (Mon

29d. Date signed (Mon

4/26)

29d. Date signed (Mon

4/26) 30. Name and address of person who 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** July 24, 2:45 A M Robert Charles Mathes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery 15316 Pine Orchard Drive #3F 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
New Jersey If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**⊠** M 2□ F Director 149-12-1112 84 July4, Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15316 Pine Orchard Drive, #3F 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Ye ar or Dates: WWI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 WWII 1 ☐Yes 2 🛮 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, the Magnes." Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Chester Charles Mathes Esther Alberta Kurtz 19a. Informant's Name/Relationship (Type. Print) 19b Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) Jeanne R. Mathes/Wife 15316 Pine Orchard Drive, #3F, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery July 27, 2009 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01548 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease Immediate Cause (Final disease or condition resulting in death) **Physician** Yeal /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a surrecytlende of) or Attending Physician: The law requires that the death certificate be executed and I-tran g physician and the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as attending | for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by 1 d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signed 2 should b 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 40 Other: 4 \(\sum \) Nursing Home 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To After th funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural (Month, Day, Year) 5 Pending 1 ☐Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29a. Certifier Medical (Check only one) nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler License number

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) JUL 2 9 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 23, 2009 7:49 P^{M} Joyce Marie Mendelson July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Montogmery Rockville 8. Date of Birth (Month, Day, October 8, 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 🕅 F Months Days Hours 52 218-66-5294 1956 Director North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 271s marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantical must be notified at anones. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 📉 No Director Maryland Montgomery 01nev 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17511 Saint Theresa Drive 20832 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jobie DuVall Violet Champion 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer A. Thorpe / Daughter 832 N. Lakeside Drive, Destin, Florida 32541 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 28, 20c. Location - City or Town, State Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licenses rejettespan 23a. Pa 11. We ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure **Physician** /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and I-transit Due to (or as a consequence of) burial-Box 68760 The law requires that the death certificate be Physician/Medical phys the t ding p IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? 1 □Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 | Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated соmpletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Brian Carpenter, M.D.

address of pers on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D64502

9901 Medical Center Drive, Rockville, Maryland 20850

29d. Date signed (Month, Day, Year)

2009

July 24,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of M	arylan		artmer			and Me		giene Reg. No./	2009	2424
Physicia		Decedent's Name (First, Middle, Last)	Margaret	. McCa	au1ev				2	2. Date of Dea Month	ith Day	Year	3. Time of Deat
/Medic Examine		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	of Death	July_	4c. (ZOU County of Dea	
Funeral Director		Riverview Nursing 5. Social Security Number 217-05-5593 6. Security Number	7. Aç	je (In yrs. i	last birthday) Yrs.	If Under Months	Esse: 1 Year Days	X If Under a Hours	Min.	B. Date of Birth (Month, Day Jan. 2	, Year)	9. Bir C	timore thplace (State or Fore ountry) arvland
yland		Usual Residence of Decedent 10a. State 10b. County		,	y, Town or Lo	cation				odii. Z	0,17	20 11	10d. Inside City Lin
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5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Executors must be confifted at	by Fur	1 ☐ Never Married 2 ☐ Married 353 Widowed 4 ☐ Divorced	Armed Forces? 1	No		fYes, spe 1 □Yes		Specify:	, Puerto Ri	ican, etc.)		Black, Whit Specify:	White
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Modical Exercitions.	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or t	5+)	16a. Deced (Give life. I	dent's Usu kind of wo DO NOT u	al Occupa rk done di se retired)	ition uring most	t of working	, [16b. Kin	d of Business	/industry
nd 21 be filed wi tal Hygier d other th	Be Cor	8 Years 17. Father's Name (First, Middle, Last)			Bing	go Ma			r's Name (First, Middle,		ngo Ha Surname)	11
Maryland Id 2 should be file Ith and Mental Hy 27 is marked oth Traumatic event	၉	Richard O Hara 19a. Informant's Name/Relationship (Ty	rpe. Print)		19b. Mailir	ng Address	(Street a		a Bob er or Rural		er, City or	Town, State,	Zip Code) 2122
re, M s 1 and 2 of Health item 27 i		Merritt M. McCaul		<u> </u>	1304 Place of Dispo				ossin Dat			ddle R	iver, MD
Baltimore, permit. Pages 1 ar Department of Hea mportant: If item iny Injury or other		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		-	ak Lawi	n Cem	etery	i i	7/30/	2009	Ва	1timor	e, Marylar
Ball permi Depar Impor		Fregom E	Kus	9_	Di 79	ıda-R 22 W	uck l ise A	Funer lve.	al Ho Dund			alk, I and 21	
Physician /Medical Examiner		23a, Part1. Enter the Isease, or lompl shock, or he if failur. It only of Immediate Cause (Endisease or condition resulting in death)	ne cause on each li	Le	mer		0	, such as	1	respiratory an	rest,		Approximate Interval Betweer Onset and Death
executed in and ial-transit	dical Examiner	Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	حمره	uence of):	leed	en	10					
	Physician/Medic	in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	Ideath 3	Ectopic p					2	3d. Date of de	elivery Day Year
that the de ned by the detached is	Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown					n in Dort I		230 Did to	shanna ur	ca cantributa t	o the cause of death
Records, P he law requires that e has been signed to	ted by	Tar ii. Other arginicant conditions con	mileumy to death b	ut not rest	and the un	idenying c	ause give	ii iii raiti.	}	1 □ Y		p	robably 4 Unkn
f Vital Rec ysician: The law is certificate has b director, page 2 sh	Completed by									24a. Was a autope perfor 1 □ Yes		prior to death?	utopsy findings avail completion of cause s 2 \Boxed No
f Vita	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital:	ant 2 🗆	ER/Outpatien	# 3 D D	Othe	-		Check only or		□Other (Spe	
on of ling Phy After thi funeral of	ion: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry	28b. Time of Injury		28c. Injury Work	at ?	28	id. Describe h			эспу)
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certificate hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i>)	ome, farm, stre			es 2□N	_	if. Location (S City or Tow	treet and n, State)	Number or F	ural Route Number,
To the Hospita within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certified	sician: To the best ner: On the basis of and manner st	of examina	wledge, death tion and/or in	n occurred vestigation	at the tim	ne, date an pinion, dea	id place, ar th occurred	nd due to the o	cause(s) date and	and manner a place, and du	as stated. e to the cause(s)
Vithir to the comp	Me	29b. Signature and title of certifier		M.C)		License	517	-1		0	e signed (Mon	108
		30. Name and address of person who co	ompleted cause of c	,	1 23a) (Type, I	Print)	n le	Den	· ve	But	Sm.	~ 2	1224
State	е	31. Date filed (Month, Day, Year)	32. Registr		Fark	,					., ,		

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar JENNIFER

31. Date filed (Month, Day,

HAYASHI

ORIGINAL

305 HOPKINS

32. Registrar's Signature

BAYVIEW CIRCLE BALTIMORE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24247 Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** July 23, 2009 2009 Harold Franklin Niven, Jr. 2:30 P /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Deeth 4c. County of Death Examiner Manor Care Chevy Chase Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 12 M 2□ F 523-16-8259 86 Yrs. Director July 2,1923 Colorado Usuel Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits th and Mantal Hygiene. ? Is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examine, must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Chevy Chase 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8806 Walnut Hill Road 20815 United States Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours aftar 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Trade Association Broadcast Educator 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be end 2 should be Harold Niven, Sr. Viola Rothrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a Important: If Item 27 is any injury or other tra Rosemary Niven/ Wife 8806 Walnut Hill Road, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of Comptent, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition July 26. 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Pumphrey Funeral Home/ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ${ t Robert \ A}$. Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814 7557 Wisconsin Ave. M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Generalized Deconditioning Examiner Due to (or as a consequence of): Examiner Hypertension The law requires that the death certificate be executed ettanding physicien end I for usa as the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Chronic Renal Failure Physician/Medical Due to (or as a consequence of) Diabetes Mellitus Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Anaemia ģ page 2 should b Completed 24b. Were autopsy findings 24a. Wes an autopsy available prior to completion of cause of death? performed' tor: After this certificate has the funerel director, page 2. TLI Yes ZIXNO 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6 ☐ Other (Specify) edical Certification: To 1 Yes 2 No 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completaly filled in by 4 - Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20274 July 23, 2009 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Kirti Vohra, M.D.7710 Bradley Blvd., Bethesda, Maryland 20817

Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

29 2009

32. Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Days Hours 1 M 2 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at MIOW +GOMETA 1 Nes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Is marked other than "natural", or items 23a or 20910 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ASIBA Specify. Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed withit ealth and Mental Hygiene. HOUSE WIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, KINDANG 16/1 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any Injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date SILVERC SPRING, MED 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-27-09 4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Service Licensee OWEZL FUNERU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzhe Alzheimer's **Physician** unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown Month Day Vear 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ Adu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No Kecurrent 1 ☐ Yes 2 ☐ No LMONIC 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 1/2001

15216 DINO DRIVE; BURTONSVILLE, MD 20864

30. Name and address of person who completed cause if death (Item 23a) (Type, Print)

MD;

CHONDHURY

31. Date filed (Month, Day, Year)

JUL 2 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ERMAN OBERFELD 2009 ULL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MILFORD MANOR NURSING HOME PIKESVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days | Hours | Min. 07/25/19 20 Birthplace (State or Foreign Country) 6. Sex 1 **X** M 2 ☐ F Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 89 PA 219-07-2592 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expression must be notified an once. 1 ☐ Yes 2 XNO **BALTIMORE** Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21208 USA 7 STONEHENGE CIRCLE, APT. 10 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔥 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 7 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No WHITE Specify: à 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR LIOUOR STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL OBERFELD UNKNOWN GUSSIE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 STONEHENGE CIRCLE, APT. 10 BALTIMORE, MD 21208 BARBARA WASSERMAN / DAUGHTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOSES MONTEFIORE CEM. 07/28/2009 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS. 21208 8900 REISTERSTOWN ROAD PIKESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2HEIMERS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atter this certificate has been s funeral director, page 2 should it Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐Yes 2 ☐No t □Yes 2 □No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated the 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature And title of certifier 285

State Registrar 2835

Arvi, m) 32. Registrar's Signature Smith

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death July 2^{Day}, **Physician** Jessica Lee Provencher-Meyers 2009 2:35A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 09/04/1977 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 31 Yrs. Funeral Months Days Hours Country) W I 394-90-7854 1 □ M 2 F Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 28a-f show the Medical Evantries must be notified at Harford MD Bel Air 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 701 High Plains Dr. 21014 USA items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White "natural", or 1 □Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "any Injury or other traumatic event, Its Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Medical Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Provencher Cheryl Wolf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5902 Memorial Highway#1316 Tampa, FL 33615 19a. Informant's Name/Relationship (Type. Print) Robert Provencher/Father July 28, 2009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facili CAFA/Stephen D.Lohrmann P.A. 8717 Green Pastures Dr. Balto, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC COLORECTAL CARCINOMA **Physician** 2007 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine spital or Attending Physician: The law requires that the death certificate be executed hearth clearth. There is certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for the control of the control of the funeral director, page 2 should be detached for the control of the Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗆 No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital of within 24 hours are To the Funeral Discompletely filled in

29b. Signature and title of certifier

29c. License number

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

eted cause of death (Item 23a) (Type, Print)

CHAPLES ST. SUITE 209 BALTIMORE, M.D 21204 6565 N

State Registrar

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year William Joseph Pagan 3:17 A Ju₁y 25, 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) N/A Johns Hopkins Bayview Medical Ctr. Baltimore City 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours New York Months 1 X M 2 □ F Aug. 19,1947 101-38-1584 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Dunda1k Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 6804 Holabird Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces 1 ☐Yes 2 XNo If Yes, Give 1 Never Married 2 Married 1 □Yes 2 🛛 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Audio Audio Installation 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carman Rosa William Pagan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk, Maryland 6804 Holabird Ave. Margaret A. Pagan (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hilltop Service Corp. 7/28/2009 Towson, Maryland 4 □ Donation 5 □ ther (Specify) 21. Signature of Entry al Service License Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical

attending physician for use as the buria

cate has been signed by the page 2 should be detached

director,

funeral

filled in by

Medical

After

after death.

within 24 hours a To the Funeral C

To the Hospital or Attending Physician: The law requires that

Physician

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

≥

Completed

Be

၉

event, the Medical Examiner must be notified at

"natural", or items 23a

hours after

within 72

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, traumany injury or other traumatic event, traumans in the Mean injury or other traumatic event, traumans injury or other traumatic event, traumans injury or other traumatic event, traumans injury or other

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

/Medical

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit the death certificate be executed

Immediate Cause (Final

in the past 12 months?

Hyperlitidemia

Melitus

☐Yes 2☐No

9 Unknown

resulting in death)

Approximate Interval Between Onset and Death 234. Part 1. Errier the disease, or complications that caused the shock, of heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Acute Myocardial Infarction Due to (or as a consequence of): High Blood Pressure Due to (or de a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Diabetes Completed Be Certification: To

1 Live birth 2 Fetal death
4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

> 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文 Unknown

Month

24a. Was an performed? 1 □ Yes 2 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

Day

Year

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ▼No 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

7 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number July 28, 2009 D0024602

Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUL Rd DOHAKKULS 21222 MD 314 GELMAN 32. Registrar's Signature AYWOND 31. Date filed (Month, Day, Year)

State Registrar

State Registrar 2434 W. BELVEDERE AVENUE BALTIMORE MD 21215 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE

snam

JUL 29 2009

31. Date filed (Month, Day, Year)

M.D

D0068394

07-24-2009

DR ALPNA ASNANI

<u> </u>			For State Registrar	State of M	aryland / [rtment of H tificate of L	lealth and M D <i>eath</i>		ene g. No. 2 ()	09	24253
	Physici /Medic		1. Decedent's Name (First, Middle, La Helen M.	Rhodes					July 23	[□] 2009	Year	3. Time of Death 11:20 AM
	Examin		4a. Facility Name (If not institution, given Riverview Care Co				4b. City, Town, or Essex	Location of Death		4c. County o	of Death	ore
	Funeral Director		5. Social Security Number 6. 9	Sex 7. Ag	ge (In yrs. last bir 80	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02/11/19	Year) 929	9. Birthp Coun Mary	lace (State or Foreign try) Land
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loc	ation				1	0d. Inside City Limits
	a-fsl	ctor	Maryland Anne Art	ındel	Brookly	m						1 □Yes 2 No
	with the Marylan ta or 28a-f show	I Director	10e. Street and Number 3614 St. Margaret	Street			10f. Zip Code	1225	10	g. Citizen of W	hat Coun	try?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 X If Yes, Give Year or Dates:	Ever in U.S. No			ispanic Origin? (Spin, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black		
21215-0036	iin 72 hc i. n "natu Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or)	1171	. Deced (Give I life. D	ent's Usual Occup kind of work done o OO NOT use retired	ation furing most of worki i)	ing 1	6b. Kind of Bus	siness/Ind	lustry
212	d within giene. er than	mo.	9	College (1-407 :	0+)	Ве	utician		I	Beauty	Salo	n
pu	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name				
Maryland	12 should be filed within h and Mental Hygiene. h is marked other than traumatic event, I'le Ma	2	Lloyd Long		T			Lot		Savag		
	and 2 sh ealth and n 27 is n		19a. Informant's Name/Relationship Leroy John Rhodes					and Number or Run ge Drive T				as 75231
Baltimore,	Pages 1 and 2 nent of Health a int: if Item 27 is iry or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐				sition (Name of eatory or other plac			0c. Location - (•	
altir	permit. Page: Department o Important: If any injury or once.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		Bayvie	22	Name and Addres		Bruzdzins	ski Fun	eral	
-	27 7 29		The	Y25				astern Ave			land	
	Physician		23a. P. 11. Emer the disease, or com show, or leart failure. List only Immediate Cause (Final disease or condition	one cause on each li	ne.	not ente	er the mode of dyin	OP P	or respiratory arres	st,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a consequence	of):		1,044 -1			_	
	Examiner	_	Sequentially list conditions,	b. Cer	etoro y	as	cular c	occide	~t			
1	ted 1sit	nine	Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	ol).		-1				
Mp.	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):	avery	Office	all!			
$\mathcal{P}_{\alpha}^{00789}$	ate be hysicia he bur	edical		.a. <u>Se</u>	1zme	-	duar	de				
	ertifica ling ph e as th	Med	IF FEMALE:		0						- !	
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 buts after death. Within 24 but persons after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		of pregnancy 2 Fetal death at time of death		Ectopic pregnancy Other (specify)	у		23d. Date Mor		ery Day Year
	ss that gned be se deta	by P	Part II. Other significant conditions	contributing to death b	out not resulting in	n the un	derlying cause give	en in Part I.	23e. Did toba	acco use contri	bute to th	ne cause of death?
ord	equire								1 ☐ Yes	2 □ No	3 ☐ Prob	pably 4 Unknown
Division of Vital Records,	The law notes that he page 2 sh	Completed							24a. Was an autopsy perform 1 □ Yes 2	ed? pi	/ere auto rior to co eath? □Yes	psy findings available mpletion of cause of 2 □ No
Vita	ician: sertific actor,	Be (25. Was case referred to medical examiner?	I I i i i			Tou	26. Place of Death				
of	Physical this call direction	P	1 Yes 2 No	Hospital: 1 ☐ Inpati		utpatien Time of		4 EN Nursing Ho	me 5 Resider			y)
o	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, Da	ay, Year)	Injury	28c. Injury Work	y at (? Yes 2 □No	28d. Describe hov	v injury occurre	ea	
Divisi	al or Atten s after deat I Director: id in by the	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Inj	ury - At home, fa lc. <i>(Specify)</i>	ırm, stre		-	28f. Location (Stre City or Town,	eet and Numbe State)	er or Rura	l Route Number,
	he Hospit in 24 hours he Funera pletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	nysician: To the best miner: On the basis of and manner st	of examination ar	e, death	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and ma te and place, a	nner as s ind due to	tated. the cause(s)
	Mithi To th	Ž	29b. Signature and title of certifie		M.D		29c. License	e number	29	d. Date signed	4/1	9
	4		30. Name and address of person who	completed cause of c	death (Item 23a)		Print) Earte	vn Are	inne b	Baltir	nor	e 21224
	Sta Registr		31. Date filed (Month, Day, Year) JUL 29 2009	Jeneral A	rar's Signature	اري						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 7,8 per fn g893 7-31-09 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July Physician 2009 4:20AM David Scott Reed /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Joseph Ritchie Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Country, 1**X** M 2□ F 289-46-6933 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be not illud at MD Baltimore Parkville 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21234 USA 8007 Old Harford Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Marine Surveyor Watercraft College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk. James W. Reed Peggy L. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 85 Dendron Ct. Balto, MD 21234 Lorie Waldon/Friend 20c. Location - City or Town, State Beltsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crem. July 29, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If It any injury or conce. 2009 22. Name and Address of FacilitCAFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 was **Physician** retactano disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be execute physician and the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Ö The law requires that the ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 11.59.15 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 sl autopsy perform 1 ☐Yes 2 No 2 🗆 No 1 ☐ Yes Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2,Cl 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Division of 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred **→** Natural 5 Pending investigation thin 24 hours area control of the Funeral Director: After the funeral by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 700 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Steet Suit 420 State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#10d, perINE G894, 8/3/09, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 21, 2009^{ear} 12:30 A M Howard William Rick 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10906 Farrier Road Frederick Frederick 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) Year) Days Hours Months 1 X M 2 □ F 165-18-9167 January 13, 1920 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 X No Maryland| Rockville Montgomery 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1412 Bernard Place 20851 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 XYes 2 □ No 1 ☐ Never Married 2 ☐ Married WWII 1 ☐Yes 2 No If Yes, Give Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Psychologist Psychology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvin Howard Mary Rick Bithell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Rick / Daughter P.O.Box 2020, Lindale, Texas 75771 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 30, 20c. Location - City or Town, State Montgomery Crematorium, Inc. Bethesda, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ocensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 latte Dufist M01305 23a. P. 11. If itel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoo, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Due to (or as a consequence of): 10 Years Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to fin mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 20 Years Coronary Artery Disease Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 🛛 No 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Daughter's Residence Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

Examiner Box 68760, Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show

permit. Pages Department of Important: If it any Injury or o

Physician

/Medical

Baltimore, Maryland 21215-0036

other traumatic event, the Modical Examiner must be notified at

Funeral Director

Completed by

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Physician/Medical

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Completed

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Medical Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed after death. l in by t within 24 hours To the Funeral

State Registrar

29b. Signature and title of certifier

29c. License number

D45048

29d. Date signed (Month, Day, Year)

July 22, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Catherine Fallick, M.D. 180 Thomas Johnson Drive, #202, Frederick, Maryland 21702

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 29 2009

and manner stated.

			For State Registrar	State o	f Marylan		artment of F rtificate of			giene leg. No.	09 24256
	Dhyoici		1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	th Day	3. Time of Death
	Physicia /Medic	al	SURA		-				07 7	26 20	09 1333 M
	Examin	er	4a. Facility Name (If not institution, LORIEN NURSING		mber)		4b. City, Town, o	r Location of Deat MDT /\	th	4c. County	of Death HOWARD
,,	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		O Birthplace (State or Foreign
	Director		217-35-4555	1□ M 2□ X F	95	Yrs.	Months Days	Hours Min.	8. Date of Birth 03/25/	1914	Country UKRAINE
	2 >		Usual Residence of Decedent 10a. State 10b. County		100 Cii	y, Town or Lo	cation				10d. Inside City Limits
	shov	ě	MD HOWAF	RD.	100. 01		COLUMBIA				1 □Yes 2 🛣 No
	28a-1	rect	10e. Street and Number				10f. Zip Code			10g. Citizen of W	/hat Country?
:	3a or	Ö	6334 CEDAR LAN	Ε				1044		USA	1
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours affer death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I fleen 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Madral Evantina mast be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🎇 Widowed 4 □ Divorced	Armed Fo	2 🔼 No ve		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🕅 No	dispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Blac	e - American Indian, k, White, etc. : WHITE
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121	ithin ne. han "	Completed by	Elementary/Secondary (0-12)	College (1		life.	DO NOT use retired COUNTANT	d)		GOVERN	IMFNT
2	Hygie Hygie ther t		17. Father's Name (First, Middle, La	est)	4	AC	COUNTANT	18. Mother's Na	me (First, Middle,	 	
Maryland	ould be the Mental Harked of attic even	To Be	SHMUEL		RING	<u> </u>		CHINI		KRIST	
	1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship ALEX SMOLYAK / I			1	LASTING				
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Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Faneral Service Li	censee	In	I	2. Name and Addre				ROS., INC. E, MD 21208
	Physician		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition	lly one cause on e	ach line.		er the mode of dyin			rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):	F182,				VICE C
G/ 3	led isit	Examiner	Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	or as a conseq	uence of):					bless
H	cate be executed physician and the burial-transit	xan	that initiated events resulting in death) Last	cDue to	(or as a conseq	uence of):	PATHY	-			
8760,	re be /sicial e buri	dical		d. Co	NGES	5410	E hE	ant 1	FAILUG	LE .	years
		ledi									
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Vital	nysıcıan; In	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or.	eath (Check only or		
		on: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date	Inpatient 2 of Injury th, Day, Year)	ER/Outpatier 28b. Time o Injury	π 3 □ DOA	ry at	Home 5 ☐ Resid	lence 6 Oth low injury occurr	
Division	Io the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: To	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	the l	of Injury - At h	ome, farm, str fy)	M 1 □	Yes 2□No	28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural Route Number,
٠ ـ	4 hours a funeral I ely filled		(Check only 2 Medical E:	caminer: On the b	asis of examina		h occurred at the ti				anner as stated. and due to the cause(s)
3	thin 2 thin 2 the I the I	Medical	one) 29b. Signature and title of certifier		ner stated.		29c Licens	se number		29d. Date signe	d (Month, Day, Year)
	≥ .≱ 5 8			ole MD			Doro	1310			
			30. Name and address of person w			n 23a) (Type	Print)	10011		0/	(alumbie
			Shawnm		up Le	965	Print) O Son	hes Re	d Sut	6 110	27 2009 Columbia MD 21045
	Sta Registr		31. Date filed (Month, Day, Year)	37	legistrar's Signa	ature La	Med	· · · ·		····	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Laverna Pauline Sowards 200 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner HOUSE Vear deGrace Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Days Min. Months 1 ☐ M 2 ☐ F 186 24 7559 78 Director 08/16/1930 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 3 Gladiolus Place 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 Widowed 4 Divorced white Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homeaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Kinsey ပ Emma Kohr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Robinson (daughter) 220 Flintstone Drive North East Maryland 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 XBurial 2 □ Cremation 3 □ Removal from State Holly Hill Mem Gardens 7/29/2009 | Middle River, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Swice Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. P. rt1. Inter the disease, or comshick, in heart failure. List only Immedia Cal se (Final disease or dition resulting in death) epalic Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate caus. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine inding physician and use as the burial-tran-Due to (or as a consequence of): Physician/Medical After this certificate has been signed by the attending promeral director, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 1000 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed3 2□No 1⊟ Yes 2E No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the

State Registrar 29b. Signature and title of certifier

5

evolution St

· MD

32. Registrar

Tram

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kammdy Milyam TM 110C Revo

29d. Date signed (Month, Day, Year)

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** James Raymond Seibles Jul 22, 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** 3709 Oakmont Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1√ M 2□ F Months I Hours **Director** Sep 7, 1936 217-34-6350 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f shov Examiner must be notified at Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. I important: If item 27 is marked other than "natural", or items 23a or i any fully or other traumatic event, Ira Modical Examiner must be not any fully or other traumatic event, Ira Modical Examiner must be not a constitution. 3709 Oakmont Avenue 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. à 3 ☐ Widowed 4 ☑ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Auto Mechanic** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula F. Seibles Eugene Seibles ပို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5515 Peerless Avenue Baltimore, Maryland 21207 Serena Roberts 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/28/09 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 212 -MGIATE 23a. Part . Enter / e disease, or complications that caused he death shock, or h. rt failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of)

Due to (or as a consequence of):

yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated

5601 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medical 2 Completed Be Certification: To after death

that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29 2009

9 Unknown

IF FEMALE

				24a. Was an autopsy performed? 1 □Yes 2 □No 1 □Yes 2 □No 1 □Yes 2 □No
25. Was case referred to medical			26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA	Other: 4 \sum Nursing Hor	ne 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year) tion	28b. Time of 28c Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determin		ome, farm, street, factory, o	office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
				and due to the cause(s) and manner as stated.

29c. License number

020396

3 🗆 Ectopic pregnancy

5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

1:00 p

Birthplace (State or Foreign Country)

10d. Inside City Limits

¥☐Yes 2☐No

So. Carolina

Day

Year

U.S.A.

Black, White, etc.

14. Race - American Indian,

Retired

Baltimore, Md.

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

29d. Date signed (Month, Day, Year)

1 Yes 2 No 3 Probably 4 Unknown

Day

Approximate Interval Between Onset and Death

Black

4c. County of Death

V State Registrar

Medical

DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral C

			State of Mary		artment of rtificate of		ınd Mental H		2000	24259	
			Registrar 1. Decedent's Name (First, Middle, Last)		i lincale oi	Dealli	2. Date of	Reg. N	02.002	3. Time of Death	
Н	Physici		William Henry Smith				Month July	24.	2009 Year		
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of			c. County of Dea		
i metri			7 Kirkhill Court		Cator	nsville	2		Balti	more	
	Funeral			yrs. last birthday)	If Under 1 Year Months Days		24 Hrs. 8. Date of Month,	Birth Day, Yea	9. Bi	rthplace (State or Foreign	
	Director		220-20-2378	2 Yrs.			Min. May 1	7, 19	927 Ma	ryland	
	and w		Usual Residence of Decedent 10a. State 10b. County 10a	c. City, Town or Lo	cation					10d. Inside City Limits	
	Maryl f sho	ţ	Maryland Baltimore	Catonsv	ille					1 □Yes 2 No	
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. 0	Citizen of What C	ountry?	
	h with		7 Kirkhill Court		212	28		115	SA		
	deat	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.			gin? (Specify Yes or Puerto Rican, etc.)		14. Race - Am Black, Whi		
36	or it	y Fu	1 Never Married 2 Married 1 X es 2 No		1 ∐Yes 2 ⊠XNo		, r dorto r frodin, otor,			hite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show wit, the Modical Examinat must be nothing at	d by		WII				104			
7	n 72	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	of working	100.	Kind of Business	s/industry	
77	withi jene. r thar	mo m	Elementary/Secondary (0-12) College (1-4or 5+)		ch Engin	•		Ba1	timore (Gas & Electr:	
b	al Hyg other	BeC	17. Father's Name (First, Middle, Last)			1	r's Name (First, Mide	dle, Maide	en Surname)		
<u> a</u>	uld be Menta Irked Itlc ev	TO E	John M. Smith			Victo	oria Sanf	ord			
Maryland	and l	ľ	19a. Informant's Name/Relationship (Type. Print)	1			r or Rural Route Nu				
Σ,	and and marking markin		Ida B. Smith Wife				Catonsvil				
Ore	ges 1 t of H If itel			0b. Place of Dispo cemetery, crer			Date		Location - City o		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maries Examinating the Inditive at once.		4 Donation 5 Dother (Specify)	Glen Hav	en Cemet	ery 8	/1/2009 Sterling	G1	en Burni	e, Maryland	
Bal	Depar mpor mpor any Ir		21. algnature of Funeral Service License		uneral F	lome of	Catonsvi	11e.	Inc.		
_	10100		23a. Part 1. Enter the disease, or complications that caused the	dooth Chroton	630 Edmo	ondson	Avenue; (laton	sville,	MD 21228 Approximate	
		8	shock, or heart failure. List only one cause on each line.			. 1		y arrest,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)		enous	leul	remia			17months	
	Examiner		Due to (or as a co							dans	
		Jer								42	
1	cuted Id ansit	Examiner	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or control of the cause of the caus								
ó	e exe ian ar irial-ti		resulting in death) Last Due to (or as a co	nsequence of):							
8760,	icate be executed physician and s the burial-transit	dical	d								
	ertific ling p e as t	Mec	IF FEMALE:							1	
9 0	eath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnar	псу			23d. Date of d Month	elivery Day Year	
P.O. Box	the de	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	e of death 5L	Other (specify)			-			
σ.	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause gi	iven in Part I.	23e. D	id tobacc	o use contribute	to the cause of death?	
gp	uires n sign Id be	Completed by	Diabetes mellitus				1	Yes	2 No 3□1	Probably 4 Unknown	
õ	w red s been shou	lete	Atherascleratio resolve	ovascu	lac d	See	10 24a. W	as an	24b. Were a	autopsy findings available	
æ	The law te has age 2 :	шо	20. 4-11		4., 6.		l aı	itopsy erformed? s 2 11	prior to	autopsy findings available completion of cause of	
ta	sician: The certificate h rector, page	Be C	25. Was case referred to medical	31 or		26. Place	1 ☐ Ye of Death (Check on		No 1 LIY€	es 2 🗆 No	
<u></u>	Physici this ce al direc		examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Ot	hor	rsing Home 5 A	/	6 ☐ Other (Sp	pecify)	
0	Attending Physician: The law requires that the death certificate are death. The death. The funeral director, page 2 should be detached for use as by the funeral director, page 2.	L:uc	27. Manner of Death 28a. Date of Injury 1 ☑ Natural 5 ☐ Pending (Month, Day, Ye.	28b. Time o	f 28c. Inju				jury occurred		
0	endii eath. or: A or: A	atic	2 Accident investigation		M 1 []Yes 2□N	10				
Division of Vital Records,		Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location City or	n (Street Town, Sta	and Number or I	Rural Route Number,	
	pital o		29a. Certifier 1 Certifying Physician: To the best of m	, knowledge, deat	h convered at the	time data con	d sleep and due to	the series	(a) and manner	an atated	
1	Hospital 24 hours a Funeral I etely filled	Medical	29a. Certifier (Check only one) 1	mination and/or in	vestigation, in my	opinion, deat	th occurred at the tir	ne, date a	and place, and di	ue to the cause(s)	
1	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Me	29b. Signature and title of continu	14 .	29c. Licer	nse number		29d. [Date signed (Mor	nth, Day, Year)	
	r > r 0		Ille & Attent	249	DI	9958	8	0	7-24	-2009	
			30. Name and address of person who completed cause of death	(Item 23a) (Type,		- 1 - (1	-		
_			Glen E. Johnson, M.D., 716 M.		oice Lan	e; Cato	onsville,	MD 2	21228		
	Sta		31. Date filed (Month, Day, Year) 33. Registrar's 3		11						
	Registr	ar	Registrar JUL 29 2009 Cerus S. Sall								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2009 JULY 26, **Physician** PHYLLIS BRIDGET SCHABDACH 8:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD BEL AIR HEALTH & REHABILITATION CTR. BEL AIR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛛 F Yrs. Director 86 214-26-8433 Aug. 17, 1922 Canada Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Exanting subst by continue at 1 ☐ Yes 2 ☑ No Director Bel Air Maryland, Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 USA 1951 Cypress Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Maonce. Elementary/Secondary (0-12) College (1-4or 5+) Public Education Cafeteria Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christine (unk) Biegler Adam Peter Diewold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2705 Stanley Dr., Baldwin, Maryland 21013 Bruce Schabdach Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State y Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn: 7-30-09 Bel Air, Maryland 21. Similar of Funeral Service Lic 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Weel wo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, in a limit of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed tours after death. The law speed by the attending physician and retail Director: After this certificate has been signed by the attending physician and filled in by the funneral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II/Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

Division of Vital Records, P.O. Box 68760, Hospital

3altimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

within 24 hours a To the Funeral C

the

Registrar

Medical

31. Date filed (Month, Day, State

4 Homicide

(Check only one)

29b. Signature and title

29a. Certifier

308 32. Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

		For State Registrar	State of I	Maryland		artment of F rtificate of		and Me		jiene leg. No.	211 H. V.	24%	261
Dharaisis		1. Decedent's Name (First, Middle, Last						2	. Date of Dea Month		Year	3. Time of	
Physicia /Medica		Sı	uzanne	Zibelli	Sc.	huck			July	27,	2009	5:55	P M
Examine		4a. Facility Name (If not institution, give	street and numb	er)		4b. City, Town, o	r Location of	f Death			County of Death		
		Montgomery Hospic	e Casey	House			ville				lontgome		
uneral		Social Security Number 6. Se		Age (In yrs. las		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8 Min.	Date of Birth (Month, Day	Year)	Cot	nplace (State ountry)	
rector		048-60-1825	□M 2XF	49	Yrs.			F	ebruary	25, 1	960 Washi	ington, I	D.C.
		Usual Residence of Decedent		10c, City,	Town or L							10d, Inside C	ity I imit
SHOW THE PERSON	_	10a. State 10b. County		TOC. City,								1 ☐ Yes	-
Ba-r	덣	Maryland Montgon	nery		вет	hesda							
Important; if item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, Irs Modical Evaning must be notified at once.	Director	10e. Street and Number				10f. Zip Code					zen of What Cou	,	
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5	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S.	13.	Was Decedent of H If Yes, specify Cub-	lispanic Orig an, Mexican	gin? (Speci , Puerto Ri	ify Yes or No- can, etc.)		 Race - Amer Black, White 		
E		1 ☐ Never Married 2X Married	Armed Force 1 ☐ Yes 2 If Yes, Give	No No		1 □Yes 2X No						hite	
E .	5	3 ☐ Widowed 4 ☐ Divorced	Year or Date	es:			-py-				Specify. W	nite	
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New Common Commo	Be (17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (First, Middle,	Maiden	Surname)		
tic e	၉	Ronald Joseph	Zibelli				Ma	ry I	rene	C1ar	k		
ma		19a. Informant's Name/Relationship (T	ype. Print)		19b. Mail	ing Address (Street	and Numbe	er or Rural i	Route Numbe	er, City o	r Town, State, Z	lip Code)	
rt a		Greg K. Schuck /	Husband		9200	Rosehill	Driv	e, Be	thesda	, Ma	ryland	20817	
othe	İ	20a. Method of Disposition		20b. Pla		osition (Name of matory or other pla		July Dat			cation - City or		
ō		1 ☐ Burial 2 🖾 Cremation 3 ☐ I				Crematorium		2009	30,	Ret	hesda, I	Marvlat	nd
Ē	-	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		TWITE	12	2 Name and Addre	ess of Facility	v					
any ii		21, Signature of Furreral Service Licens	1	м0130	R	obert A. Pu	mohrev	Funera	1 Home/	Rock	ville, Ind	2.	000
		regraphes Im	NUT		10	00 West Mon					. Marvlan	d 20850- Approxima	
	- 1	23a. Part 1 Enter the disease, or comp shock, or heart failure. List only of	ne cause on eac	sed the death. h line.	Do not er	iter the mode of dyl	ng, such as	cardiac or	respiratory ar	rest,		Interval Be Onset and	etween
dical iner	lical Examiner	Sequentially list conditions, if any, leading to min odate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Seizu	as a conseque	order								
, e	ğ		d										
for use as	Physician/Med	IF FEMALE:	23c. If yes, outco	me of pregnan	су						23d. Date of del	iverv	
for u	ä	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal on the state of the		☐ Ectopic pregnand ☐ Other (specify) _	су			- "	Month	Day	Year
be detached	ysi	1 □ Yes 2 🔯 No 9 □ Unknown	9 🗆 Unknov										
		Part II. Other significant conditions co	ontributing to deat	th but not result	ing in the	underlying cause gir	ven in Part I.		23e. Did to	obacco i	use contribute to	the cause of	death?
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S Z	Completed								24a. Was autop	SV	24b. Were au	topsy findings completion of	s availa cause
Page	ē								l norfo	rmed? 2 🔯 No	I death?		
5	BeC	25. Was case referred to medical					26. Place	of Death	(Check only o				
		examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1□ Inc	oatient 2 🗆 E	R/Outoatie	ent 3 DOA Otl	her: 4 🗆 Nu	ursing Hom	e 5∏ Resid	dence	6 X Other (Spe	cify) Host	oice
a	٥	27. Manner of Death	28a. Date of	Iniury 2	28b. Time				3d. Describe I				
<u> </u>	ģ	1 Natural 5 Pending 2 Accident investigation	(Month,	Day, Year)	Injury		rk?]Yes 2 🗍	No					
completely filled in by the	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	f Injury - At hom J, etc. <i>(Specify)</i>	ne, farm, s	I treet, factory, office		28	3f. Location (8 City or Tov		nd Number or Ru e)	ural Route Nu	mber,
letely tille	Medical C	29a. Certifier 1 Certifying Ph. (Check only one)	ysician: To the b iner: On the bas and manne	is of examination	ledge, dea	ath occurred at the tinvestigation, in my	time, date ar opinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s	s) and manner a d place, and due	s stated. to the cause	(s)
dwo	Me	29b. Signature and title of certifier			_		se number			29d. Da	ite signed (Mont	h, Day, Year)	
)		J. Wuelch	ou, x	mD		06	37 L	3		Ju	ly 28, 2	2009	
					:								
		30. Name and address of person who					Daad	D	1e37-111 -	Μ.	. r. r. 1 . r. J	20855	
		Jocelyne Kouatcho				ster Mill	_ Koad	, KOC	KAITTE	, Ma	iryrand	20033	
	te	31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signatu	re	11							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05773 State of Maryland / Department of Health and Mental Hygiene Ronald Leroy Skillman 1- For State Certificate of Death Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2143 hrs July 23, 2009 **Medical Examiner** Ronald LeRoy Skillman c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Edgewood Bush River @ Wilson Point If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min Hours Months Days Country) Director <u> April</u> 219-36-1511 Maryland 1 X M 2 F 69 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Ę 1 Yes 2 X No 28a-f show Harford Aberdeen Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be notified USA 21001 2100 Park Beach Drive 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. or items Armed Forces? 1 Never Married 2 Married 1 X Yes Specify: White If Yes, Give Year Yes 2 X No specify: 3 X Widowed 4 Divorced timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hours after trent of Health and Mental Hygiene.
Triant: If item 27 is marked other than "natural", yor other traumatic event, the Medical Examiner. à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Construction Superintendent 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Margaret McGuigan Be Harry LeRoy Skillman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Itimore, MD 2561 Giles Mill Road, Bunker Hill, WV 25413 Vicki L. Martel / Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Towson, Maryland Hilltop Service Corp. 7-27-09 Donation 5 Other Specify 22. Name and Address of Facility.
McComas Funeral Home, P.A. 21. Sign we're of Funeral Service Licenses 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Death Medical Drowning Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): Exar events resulting in death) Last and hysician/Medical 23a,pt.II,27,28a-f per me g894 8-20-09 vt X UNPENDED e attending physician for use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 23c. If ves. outcome of pregnancy 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown signed by the be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 立 P.O. Yes 2 No 3 Probably 4 ✔ Unknown \$ Hypertensive Atherosclerotic Cardiovascular Disease Completed Division of Vital Records. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy . death? has performed? 2 Nα ✓ Yes 2 No 1 🗸 Yes certificate h 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: 1 examiner? Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 ✓ Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Natural Yes 2 X No Pending subject fell in water within 24 hours after death.

To the Funeral Director: Director: 7-23-09 2138 hrs Investigation 2 X Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Bush River@ Wilson Ht. Suicide Edgewood, determined (Specify) river Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical

State Registrar 29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day,

and manner stated.

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

July 24, 2009

29d. Date signed (Month, Day, Year)

Marcus	A	ntonio Sanch	nez								
09-05799		Please Type of	or Print in Black	c Indel	ible Ink. E	nsur	e All C	opies Are L	egibl		
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Physicia		Registrar 1. Decedent's Name (First, Middle,La:		Certino		-		2. Date of D			3. Time of Death
Medical Examin	W	MARCUS ANTONIO SA						Month July 25,	2009	Year	0226 hrs
P.		4a. Facility Name (if not institution, given	ve street and number)				Location of	Death	4	c. County of Death	
	4	Johns Hopkins Bayview N		van loot hin		more der 1 Yea	r If I Inder	24Hrs. B. Date of	Righ (MN	VDD/YYYY 9. Bir	tholace (State or
Funeral Director		5. Social Security Number 6. S	M 2 F		Mont			Min		Foreig	untryHONDURAS
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7 any	İ	10a. State 10b. County	10c.	City, Town	or Location						10d. Inside City Limits 1 X Yes 2 No
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death with the Maryland or items 23a or 28a-f sho must be notified at once	Director	10e. Street and Number				p Code					illy!
rith the 1.23a o		316 S. NEWKIRK A	VE. 12. Was Decedent Ever	in U.S.		224 lent of His	spanic Origi	n? (Specify Yes or		DURAS 14. Race - Amer	ican Indian, Black,
eath w	Funeral	1 X Never Married 2 Married	Armod Forego?		If Yes, spec	ify Cubar	n, Mexican,	Puerto Rican, etc.)		White, etc.	
after d	Ę.	3 Widowed 4 Divorce	d If Yes, Give Year or Dates:					HONDURAS		Specify: WHI	
hours		15. Decedent's Education (Specify of	The state of the s	ed) 16a.	Decedent's Usua during most of wo				16b.	Kind of Business/	Industry
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s, M and 2 lealth a		PEDRO PERES/FRIE 20a. Method of Disposition			of Disposition (Na	me of ce	metery,	Date	20c	Location - City or	
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Baltimore, permit. Pages I an Department of Hea Important: If iter	ı	4 Donation 5 Other Specifical Signature of Fundal Service Lice		SALV U		d Addres		WESLEY CH			
E Per C	1	Mesley Cha	vin		2007-	-09 E	ASTER	N AVE., E	BALTI	MORE, MI	21231 Approximate Interval
Physician //Medical		Aa. Part I. Enter Me disease, or comfailure. List only one cause on e	each fine.		not enter the mode	e of dying	, such as ca	rdiac or respiratory	arrest, si	nock, or neart	Between Onset and Death
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	iner	if any, leading to immediate	Due to (or as a conseque	nce of):							
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Box 68760, e death certificate be execute the attending physician and ed for use as the burial - tra	Physician/Medical	UNPENDED	AMENDED 23c. If yes, outcome of	forogogo					12	3d. Date of deliver	
1876 tificat ing phy as the	M/W	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth		y 2 Fetal deat	h 3	Ectopic	pregnancy	٦		Day Year
OX 6 ath ce	Sici	1 Yes 2 No 9 Unknow	4 Pregnant at time 9 Unknown	of death	5 Other (Sp	ecify)					
the de by the ched f	F	Part II. Other significant conditions		not resulti	ng in the underlyir	ng cause	given in Pa	rt I. 23e. D	id tobacc	co use contribute to	the cause of death?
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al R	Be C	25. Was case referred to medical examiner?				26 Plac		Check only one)			
Division of Vital Records, P.O. Box 68760, fallor Attending Physician: The law requires that the death certificate be starder death. In Director: After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the bu	ם	1 🗸 Yes 2 No			Outpatient 3	DOA	Other4	Nursing Home 5		dence 6 Othe	er:
ding P		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) Jul 25, 2009		o. Time of Injury 01 hrs	I _	uryatvvoik Yes 2. ✔	Subject s		rijary occurred	
Atten rector by the	icati	2 Accident Investiga	28e Place of Injury	- At home,	farm, street, facto	ry, office	building, et				ural Route Number, City
Divisior ospital or Attend hours after death neral Director: y filled in by the	Certification:	3 Suicide 6 Could no determin		Street				or Tow 5100 Fost	n, State) er Aven	ue, Baltimore, M	ID
H 4 T 5		29a. Certifier 1 Certifying Physi	cian: To the best of my kn	owledge, d	leath occurred at t	he time, o	date and pla	ice, and due to the	cause(s)	and manner as sta	ited.
To the comple	Medical		and manner stated.	ation and/or			se number			d. Date signed (M	
	2	29b. Signature and title of certifier		10	,		.M.E.			ıly 25, 2009	
		30. Name and address of person wh	completed cause of death	(Item 23a)						
1	3	Russell Alexander MD.	Assistant Medical I			Street	t, Baltimo	ore, MD 21201			
		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	ale						
Regist	ırar	JUL 2 9 2009	poreur p	19	West		_	0	CME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** VERONICA SMITH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** General Baltimore N/A aryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7-27-1949 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F PENNA. 59 217-50-1542 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show direal Examiner must be notified at 1x Yes 2□No N/A **Funeral Director** BALTIMORE MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural"; or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be no once. 2303 TERRA FIRMA RD. APT A3 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: BLACK Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DIETARY HOSPITAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VERNON ROBINSON ARRI OWENS P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOY SMITH (DAUGHTER) 8365 TAMER CT. APT A48 COLUMBIA, MARYLAND 21045 20a. Method of Disposition

Burial 2 Gremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7-31-2009 3 □ Bemoval from State ☐ Other (Specify) GARRISON FOREST VETERANS OWINGS MILLS, MARYLAND 4 ☐ Donation HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Faneral Licensee JONATHAN D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate cause (Final disease). **Physician** disease or condition resulting in death) /Medical Du-, o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the ar 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has e 2 page After this certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the fineral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident Injury Division 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier t 👿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

Kobina Kana M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 6:50 AM Physician July Tenry 2009 1 arver /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel BALTIMORE WASHINGTON MEDICAL CENTER Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 🗆 F 253-72-3057 65 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r 28a-f show notified at 1 ☐Yes 2X XNo Odenton Anne Arundel Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examinat must be no once. USA 21113 833 Moonridge Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Wes 2. No If Yes, Give 14, Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+)
N/A Elementary/Secondary (0-12) Food Service Specialist United States Army 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hutchinson Sr. Mary ပ Tarver Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 833 Moonridge Ct. Odenton, MD 21113 Deborah Schexnayder-sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 7/29/2009 Greenmount Crem. : 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST E. North Avenue Baltimore, MD 21202 was 1101 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardicl hour disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Diseag Renal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary after death.

Director: After this certificate has in by the funeral director, page 2 s autopsy performe 1 ☐ Yes 2 🗷 No Diabetes Mellitus 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours aft e Funeral Di letely filled in 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0068123 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie, MD 21061

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State Registrar

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Drive Haspital

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			1- For State Registrar	-	Certifica	ate of Dea	ath		Reg. No	20	109 2	1.28
	Physici I Exami		Decedent's Name (First, Middle George Harris !					2. Date of Month July 23		Year	3. Time of Dea 2242 hrs	
			4a. Facility Name (if not institution Interstate 70 Eastboun				y, Town, or Location gerstown	of Death		c. County of D Washingto		
	uneral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birt		nder 1 Year If Und	rs Min.	,	1	. Birthplace (State o Country)	r Foreign
	rector		213-11-1123 Usual Residence of Decedent	XXM 2 F	39	Yrs.		Oct.	23,	1969	Canada	
	w any		10a. State 10b. County		10c. City, Town						10d. Inside Cit	
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ć	iral", o	т.	3 Widowed 4 Divo	or Dates:	89–1992		No specifical Occupation (Give	y: e kind of work done	116h	Specify:	White	1
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AD 2	2 should a and M 27 is m matic e	To	19a. Informant's Name/Relationsh Nancy M. Tutor					westminst				
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Baltimore, MD	Department o Important: injury or oth		4 Donation 5 Other Specific Linear e of Funeral Service L	ecify:	Memor	ey Val	Ley Cdens and Address of Facil	2009	T		m, Maryla	nd
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	ysícian Iedical	1	23a. Fan I. Enter the disease, or continue. List only one cause of	complications that caused on each line. a. Multiple Injuries		ot enter the mod	de of dying, such as	cardiac or respirato	y arrest, s	hock, or heart	Approximate Between Or Deat	nset and
×	aminer	3.	In mediate Cause (Final disease or condition resulting in death)	Due to (or as a conse								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):							
\v -	ed Isit	Examine	(Discuss or hjury that initiated events resulting in death) Last	Due to (or as a conse	equence of):							
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8760	incare o ig physi- is the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	me of pregnancy	Fetal dea	eth 3 Ector	pic pregnancy	2	23d. Date of de		rear
Box 68760,	e death certificate be exe the attending physician a ted for use as the burial -	Physician/Medica	past 12 months? 1 Yes 2 No 9 Unkr	4 Pregnant at	time of death	Other (S						
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Division of Vital Records, P.O.	ate has b	Completed							autopsy performed Yes 2	? dea	r to completion of ca th? Yes 2	ause of No
italF	s certific rector, p	Be	25. Was case referred to medical examiner?	Hospital:	ent 2 ER/O	utpatient 3	26.Place of Dear	th (Check only one) Nursing Home	5 Paci	dence 6 🗸	Other: Scane	
of .	ng rnys After thi uneral di	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	In/ 28h	Time of Injury	28c. Injury at Wo	ork? 28d. Des	cribe how i	njury occurred oter crash	Other Ocene	
ision	r death. ector: by the f	icatio		tigation Jul 23, 2009	223	JND: 1 hrs arm, street, fact	1 Yes 2 ory, office building,	No			or Rural Route Num	ber. City
Div	ours afte	Certification:	4 Homicide determ	not be	jor Road / H		,	or To	wn, State)		nm, Hagerstown,	
	To use another or assenting rejection; The taw requires that the death centuriate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (ysician: To the best of m								
1	To To	Meo	29b. Signature and title of certifier	and manner stated.			29c. License numbe		290	d. Date signed	(Month, Day, Year)	
			30 Name and address of person v				O.C.M.E.		Ju	uly 24, 2009		

State 31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature ORIGINAL

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Donna M. Vincenti, MD

JUL 2 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 26 LORETTA BLANCHE THOMPSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner tizen's Nursing Debrace Harford Home taure If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Aug. 27, 1937 Maryland Director 215-34-0541 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Show at r 28a-f sh notified 1 □Yes 2 No Director Maryland Harford Havre de Grace 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or must be r USA 3942 Deer Park Ct. 21078 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. "natural", or items 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify Be Completed by 3 Widowed 4 ☐ Divorced White 7 Is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) School Bus Driver Public Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 Is marked oth P Delbert Romy McCoy Janice Mary Rogers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2.
ment of Health a
ant: If item 27 Is
ury or other trau 3942 Deer Park Ct., Havre de Grace, Maryland 21078 Michael A. Thompson / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or 4 □ Donation 5 □ Other (Specify) Rock Run U.M.Chr. Cem. 7-30-09 Havre de Grace, MD 21. Signatur Funeral Service Licens 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHYLIOMY SPIMMY Physician /Medical Due to (or as con equence of) Examiner Sequentially list conditions as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last amilinia death certificate be executed the burial-tran as a consequence of) Due to (dr Physician/Medical use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 No 1∐ Yes 2 No 1 ☐ Yes Fo the Hospital or Attending Physician: 25. Was case referred to medical 26. Place Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 □ FR/Outnatient 3□ DOA 1 ☐ Inpatient Division or nours after death.

neral Director: After this y filled in by the funeral d 27. Manuar of Death 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifler 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler

State

303 Name and address of person who complete

31. Date filed (Month, Day, Year)

of death, (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥎 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 27, 2009 Ju₁y 1:15 Α William Tokarcik Joseph 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Hospice Casey House Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year) Days 1 X M 2 □ F September 9, 1928 Pennsylvania 80 168-22-7228 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Maryland Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 702 Woodburn Road 20851 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married WWII 1 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States College (1-4or 5+) Elementary/Secondary (0-12) Industrial Engineer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Tokarcik Julia Seman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tokarick / Wife 702 Woodburn Road, Rockville, Maryland 20851 Joanne 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 31, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 2009 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licenses M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. In ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer Due to (or as a consequence of) Sequentially fist conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2X No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 K Other (Specify) 1 ∐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Division of Vital Records, P.O. Box 68760 funeral director, death. Director: or A

> State Registrar

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examine

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Completed

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Certification: To

29b. Signature and title of certifie

J. KULLEL

Jocelyne Kouatchou, M.D,

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at

al Hygiene.

ages 1 and 2 should be file ont of Health and Mental Hy t: If Item 27 Is marked oth

Pages 1

Injury or other

Physician

/Medical

the burial-trar

attending pl

Examiner

Baltimore, Maryland 21215-0036

32. Registrar's Signature 31. Date filed (Month, Day, Year) 29 2009

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 763748

6001 Muncaster Mill Road, Rockville, Maryland 20855

29d. Date signed (Month, Day, Year)

July 28, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 213 らいら 10c BY 93 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1-10-5pitul Byltimone Ci 8. Date of Birth (Month, Day, Year) N/ADECOYL 5 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2 □ F Yrs. MARYLAND Director 5-24-1943 66 219-40-8704 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Micral Exercited to the traumatic event, Item Microl Exercited to the traumatic event, Item Microl Exercited to the traumatic event, Item Microl Exercited to the traumatic event, Item Microl Exercited to the traumatic event, Item Microl Exercited to the traumatic event, Item Microl Exercited to the traumatic event, Item Microl Exercited to the traumatic event, Item Microl Exercited to the traumatic event, Item Microl Exercited to the traumatic event, Item Microl Exercited to the traumatic event, Item Microl Exercited to the traumatic event ev 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 XYes 2 No BALTIMORE MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2844 W. MULBERRY ST. 21223 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSING -0-MAINTENANCE -6-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GOLDIE TAYLOR ပ MITCHELL WELLS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 812 N. BENTALOU ST. BALTIMORE, MARYLAND 21216 KIM TAYLOR (BAUGHTER) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other 3 Removal from State ARBUTUS MEMORIAL PARK 7-29-2009 BALTIMORE, MARYLAND Other (Specify) D. HIBNER. Name and Address of FacilityREDD FUNERAL SERVICE 21. Signature of F AHT ANOU 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part / Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final disease or condition resulting death) **Physician** Atwardicterati CURONAS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a consequence of burial-tran Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 DAK 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, ours after death.

leral Director: A
filled in by the fu within 24 hours a

> State Registrar

4 Homicide

29b. Signature and title of certifier

Date filed (Month, Day, Year)

) relie

29 2009

RiBins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29a. Certifier (Check only one)

7030 WEST

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

545EE+

09-05818 James Vines

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

allies v	VIIICS		For State Registrar	Ce.	rtificate of		a ivionital in	Reg.	No.	200	0 21.27			
	Physicia	an/	Decedent's Name (First, Middle,Last)		1/:			2. Date of Death Month D July 25, 200	ay Ye		3. Time of Death 7 4- 7			
viedica	al Exami		James 4a. Facility Name (if not institution, give	street and number)	Vines 4	b. City, Town, or	Location of Death	July 25, 200	4c. County					
			13 Centre Avenue			Dundalk				re Cour	-			
	Funeral Director			7. Age (In yrs.	last birthday) 73 Yrs.	If Under 1 Yea Months Day		_		Cour	place (State or Foreign htry)			
	any	1	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location						10d. Inside City Limits			
	ž .	ō	Maryland Baltimo	re	- L	undalk			. Citizen of W		1 Yes 2 X No			
3	Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inter If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.	- 1	10e. Street and Number 13 Centre Avenue			10f. Zip Code 212.			USi	4	an Indian, Black,			
	death wit r items 2 nust be r	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in L Armed Forces? 1 Yes 2 X No	If Ye	es, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto		Whi	te, etc.				
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213	hould be fil nd Mental I is marked atic event,	10	19a. Informant's Name/Relationship (Ty	pe, Print)				Rural Route Numb						
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Baltimore,	or ar		Burial 2 X Cremation 3 Donation 5 Other Specify:	Be	crematory or oth	remator	y 20	009			Maryland			
Balt	permit. Pag Department Important: injury or of		21 Signature of Funeral Service Licens	onnel	ly 200	nnelly 10 Soll	Funeral i ers Poin	Home of 1 t Road, 1	Oundal Oundal	k, P. A k, Mar	yland 21222			
	nysician Medical		23a. Part I. Enter the disease or complifailure. List only one cause on each	h line.	th. De not enter the	he mode of dying	, such as cardiac	or respiratory arres	t, shock, or h	neart	Approximate Interval Between Onset and Death			
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		L	Sequentially list conditions, b.		-f).						<u> </u>			
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Box 687	The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physician/	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of	death =	ther (Specify)								
B	the dea by the a ched fo	Phys	Part II. Other significant conditions	g Unknown contributing to death but not	t resulting in the	underlying cause	given in Part I.	23e. Did tob	acco use co	ntribute to	the cause of death?			
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requi within 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	n: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of	Injury 28c. Inj	ury at Work?	28d. Describe h	ow injury occ	urred				
sion	Attendi death. ctor: /	atio	1 Natural 5 Pending 2 Accident Investigation	Fd 7/25/09	FD 6:5	1 pm	Yes 2 X No	unk	treet and Nu	mber or Ri	rral Route Number, City			
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	a C	29a. Certifier 1 Certifying Physici	an: To the best of my knowle	edge, death occu	irred at the time,	date and place, ar	nd due to the cause	e(s) and man	ner as stat	ted.			
(5)	To the Ho within 24 To the Fu completely	Medical	one) 2 ✓ Medical Examiner 29b. Signature and title of certifier	On the basis of examination and manner stated.	and/or investiga		on, death occurred	at the time, date a			onth, Day, Year)			
		-	mid H	200an			C.M.E.		July 26,	2009				
	d		30. Name and address of person who			Otrock D. III	ND 010							
8	0 1			nt Medical Examiner 32. Registrar's Sign.		Street, Baltir	nore, MD 212							
	Regis	tate strar	1111 0 0 04			ake								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Pers Phy of Mary 8/05/199 partment of Health and Mental Hygiene amend #1 Per Phy G894 Sertificate of Death Reg. No. 1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Van Sant VanSant Jeannette Month **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 15 GRANARY DRIVE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Months 1 ☐ M 2 🗹 F 218-22-2895 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Expr. in a count of a southed at 1 ☐ Yes 2 X No Director BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 15 GRANARY DRIVE 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 X If Yes, Give Year or Dates: WHITE 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If an ance. Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN_HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ABRAHAM** MILLSTEIN SARAH GOTTL I EB ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ALLEN VANSANT / HUSBAND <u>15 GRANARY DRIVE, BALTIMORE, </u> MD. 21208 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 07/28/2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State REISTERSTOWN, MD DHEB SHALOM MEMORIAL PARK | KEISTEKSTUWN, I 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign yur of Funeral Service Lice ee 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): KINSON Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burlal-transit Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, attending ph for use as th IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manne Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D20658 teath (Item 23a) (Type, Print) W. Belvedere #202, BATIMPRE, W2/208 30. Name and address of person wh 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 29 2000 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2000 **Physician** 2:30 pM Selena Katherine Waller /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Stella Maris Examiner Timonium Balto Birthplace (State or Foreign Country)
 VA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 224-30-6417 7. Age (In yrs. last birthday) Funeral Days Hours 1 □ M 2X F Yrs Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show 1XYes 2 No MD N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 USA 812 E. 22nd Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Black 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Ž No Specify: Baltimore, Maryland 21215-0036 5 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the McClical once." 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) A Elementary/Secondary (0-12) Goucher College Health Aid 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Walker James Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21218 22nd Street Betty House-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Pk Date 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-28-2009 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tipe. Approximate Interval Between Onset and Death - Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) the detached 9 Unknown 9 Unknown After this certificate has been signed by inneral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. /2000 Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1/200 00/12 performed? Yes 2010o 1 ☐ Yes 2 ☐ No 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Tes 2 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending 1 □Yes 2 □No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital rtifing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medical completely (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15508 1000 JULY 22, 2009

DHMH 17 Rev 1/2001

State Registrar

SELENA

2300 DULANEY VALLEY ROAD

21093

TIMONIUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

EDDIE NAKHUDA,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 7-25-2009 H. Williams, Sr /Medical James 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Overlea Rehabilitaion Center Balto If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-15-1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1**∑**M 2□ F Months Davs Min. Hours 85 N.C. Director 242-22-0468 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show traumatic event, the Medical Expuriment ust be notified at XXYes 2 □ No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 23a USA 21205 914 N._Lakewood Avenue Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 📉 No Specify Black Specify: ş 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of MD e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Montebello State Nursing Assistant 7th grade N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental f Health and Menta item 27 is marked Sophie Williams ဥ Edward Michael Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21205 914 N. Lakewood Avenue Elizabeth Williams-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-31-2009 Balto, MD Loudon Park Cem 4 Donation 5 Dother (Specify) March East F/H 21. Signature of Fundal Service U 22. Name and Address of Facility Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final tote hour **Physician** disease or condition resulting in death) ar /Medical Due to (or as a consequence of): Examiner eguve if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed enred ned by the attending physician and detached for use as the burial-tran Division of Vital Records, P.O. Box 68760,arphiDue to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No certificate 1 Tyes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2MNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 1 Whatural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury af Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month-Day, -Year)

30. Name and address of person who completed cause of death (Item 28a) (Type, Pring 18 Minute . 32. Registrar's Signature

ORIGINAL

Blud.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Michael S. Woerner, Sr. 07-24-2009 0256 Α /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-10-1963 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Days Hours **1**∑ M 2 □ F 46 MD Director 220-90-7598 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygeine. In Permit In Permit In Permit In Permit In Permit In Permit In In In It I fam 23a or 28a-f show Important: If I fam 27 is marked other than "natural", or I fems 23a or 28a-f show any in Jury or other traumatic event, the "natural Exercities or mat ta muffiled at 1 ☐ Yes 2 No Director Joppatowne MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 806 Foxwell Rd 21085 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 👿 No Specify: 2 Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John M. Woerner Jr Joan M. Rog 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Woerner (Mother) 1430 Oakdale Rd Glen Burnie, MD 21060 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-28-2009 Baltimore, MD Bayview Crematory 21. Signature of Euneral Servic 22. Name and Address of FacilitySchimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 0 Approximate Interval Between Onset and Death B mony 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** months OR ONITE /Medical Due to (or as a contequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and burial-trar Due to (or as a consequence of) Physician/Medical for use a If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 certificate 1 ☐ Yes 2 ☐ No OBES IT 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XER/Outpatient 3 □ DOA ၉ 1 Tyes 1 🔲 Inpatient funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier **Medical** (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature PROSSER

State Registrar 31. Date filed (Month, Day, Year)

			,	1 - For State Registrar	State o	f Marylar		artmen rtificate					Reg. No.	2009	24275
		Physici		Decedent's Name (First, Middle MARY GWEND		Δ						2. Date of De. Month JULY 23	Day	Yeer	3. Time of Death 5:47 A M
		/Medio Examir		4a. Facility Name (If not institution HARFORD M			PITAL	4b. City,	Town, or	Location (of Death	RACE	-	County of Death HARFO	ORD
		Funeral Director		5. Social Security Number 416-32-9562	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 81	last birthday, Yrs.	Months Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Mar. 8,	y, Year) 192	9. Birth Cou 8 Ohio	place (State or Foreign ntry)
		land ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or L	ocation							10d. Inside City Limits
		death with the Maryland me 23a or 28a-1 ehow count be notified at	Director	Maryland Harfo	rd	Ed	gewood			1					1 ☐ Yes Ž No
		with th	Dire	10e. Street and Number 2203 Perry Av	2			10f. Zip	Code 1040				10g. Citiz	zen of What Cou	ntry?
		death me 23	Funeral	11. Marital Status		edent Ever in U	J.S. 13.			spanic Or	igin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Ameri Black, White,	
1	920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show may injury or other traumatic event, the Madical Examinat must be notified at ance.	by	1 Never Married 2 Mar 3 Widowed 4 Divorced	ned 1 ∐Yes If Yes, Gir	2 (X No		1 ☐ Yes		Specify		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Specific	hite
7	21215-0036	in 72 ho n "natur	Completed	(Specify only highe	t's Education st grade completed)	1.1-5.)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us	al Occupa rk done d se retired,	ation during mos	st of work	king	16b. Kir	nd of Business/Ir	ndustry
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0	Aary	2 shound N and N ie mai		19a. Informant's Name/Relations				-						Town, State, Zi	Code)
0		s 1 and if Health item 27 other t		Dorothy J. Dieh 20a. Method of Disposition		20b.	Place of Disp cemetery, cre					Date		TL 32821 cation - City or T	own, State
23	altimore,	Page Iment o tant: If jury or		1 ☐ Burial 2 🗷 Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	State	lltop	Servi	ce C	orp				son, Mar	yland
1	Bail	permit Depar Impor eny in		21. Signature of Funeral Service	Meer 13		2	McCom 1317	as Fi Coke:	s of Facil unera sbur	il Ho V Roa	ome, P.A ad, Abir	A. ngđon	n, Maryl	and 21009
		Division		23a. Part1. Enter the disease, o shock, or heart failure. List	complications that conly one cause on a	eaused the dea	ath. Do not en	ter the mod	le of dying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	1	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to	(or as a conse	quence ol):	(a. 1)		I M	n00	HAGI	_		
			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conse	quence of):	VOIL	١ ١	(2/11)	UNN	11176			. 23 21
	7	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	quence of):	_							
	8760,	0 0	dical						7 A T						
	P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live I	tcome of pregr birth 2 Fet nant at time of lown	tel death 3	□Ectopic pi □ Other (sp					2	23d. Date of deli Month	very Day Year
>		uires that signed b ild be deta		Part II. Other significent conditi	ons contributing to d	leath but not re	sulting in the	underlying o	ause give	en in Part	1.		tobacco u Yes 2[the cause of death?
Ma	Il Records,	sici an : The faw requ certificate has been rector, page 2 should	Completed						-			24a. Was auto perfe 1 Yes	psy ormed?		opsy findings available ompletion of cause of
_	Vital	Physician: this certificated ral director,	Be	25. Was case referred medica examiner?	Hospital:		7500		Othe	or.		th (Check only		- CO.	Z. (
D	n of	ding Phys h. After this funeral di	lon: To	1 Yes 27 No 27. Manner of Death 1 Natural 5 Pendi	28a. Date		⊒ ER/Outpatie 28b. Time Injury		28c. Injun Worl	v at		ome 5 ☐ Resi 28d. Describe		6 □Other (Spec y occurred	ify)
216	Divisio	or Attendated after death	Certification:	2 Accident Invest 3 Suicide 6 Could 4 Homicide	200. Place	e of Injury - At ling, etc. <i>(Spe</i> c	home, larm, s cify)			163 2	J140	28l. Location (City or To			ral Route Number,
3	<i>-</i>	Hospitel 24 hours a Funerel itely filled	Medical Co		ng Physician. To the Examiner: On the b										
	8	within 2 To the complet	Med	29b. Signature and title of certific	1	AAS		29	c. License	e number	01		29d. Dat	te signed (Month	, Day, Year)
				20 Name and adds	///	[V]]) am 23a) /Tur-	Print)	10	624	06		01	JLY, 2.	3,2009 MD21098
	-			30. Name and address of person	MADEH,	501	SOUTH	ONI	ON I	AVE.	, H	AURE i	EG	RACE	MD 21093
		St Regist	ate rar	31. Date filed (MOUT) Day Year	2009	Registrar's Sign	1. Sa	res							

			For State Registrar	State of Ma	aryland /		rtment of h			ental Hy	gien Reg. N	000	0 21.274
			1. Decedent's Name (First, Middle, Last)						2. Date of De	eath		3. Time of Death
	Physicia /Medic		Bruce	e Keirn	Wetz	el				July	2	7, 2009	7:30 A M
No.	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, c				40	c. County of Dea	
			7615 Cabin Road				Cabin					Montgon	
ì	Funeral Director		271-32-0047	X 7. Ag ZM 2□F	e (In yrs. last bi	Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bir (Month, Di January	rth <i>ay, Year</i> 24 ,	1936 Ohi	thplace (State or Foreign ountry) .O
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	yn or Lo	cation						10d. Inside City Limits
	/laryla	or	Maryland Montgome	~3 7			n John						1 □ Yes 2 🕅 No
	the 1	Director	10e. Street and Number	<u> </u>		, 401.	10f. Zip Code				10g. C	Citizen of What Co	ountry?
	3a o		7615 Cabin Road				208	18			U	nited St	ates
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Vas Decedent of F f Yes, specify Cub	Hispanic O	rigin? (Spe	ecify Yes or No	0-	14. Race - Ame	erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examitrer mast be profibed at once.	by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏Yes 2 XIII If Yes, Give Year or Dates:	No		Yes 2X No			nican, etc.		Black, Whit Specify: V	Nhite
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication	168	a. Deced	lent's Usual Occup	pation	et of workin	na .		Kind of Business	•
2	ithin ne. M	nple	Elementary/Secondary (0-12)	College (1-4or 5	(+) Re	sear	kind of work done O NOT use Tetire Ch Cell	Biol	ogist	,g /	1		nstitutes
2	led w lygier her th		AT F II I AL (Fine Add to Local)	5+	Sc	ient	ific Revi	ew Adm	ninistr	ator		Health	
Maryland	d be fi	Be c	17. Father's Name (First, Middle, Last) Ralph Earl Wetzel	1						(First, Middle M. Kei		n Surname)	
<u> </u>	should Me Me mark	욘	19a. Informant's Name/Relationship (7)		19	b. Mailin	g Address (Street	1				or Town. State.	Zip Code)
Š	nd 2 alth a alth a 27 is		Sandra J. Occhipin		e 76	515	Cabin Ro	ad, C	abin	John,	Mar	yland 20	818
ĕ,	of He of He item		20a. Method of Disposition	*	20b. Place o	of Dispo	sition (Name of natory or other pla	ce)	July	^{ate} 29,	20c. l	Location - City or	Town, State
altimore,	Page nent ant: If ury o		1 ☐ Burial 2 🖾 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,				Crematorium		200		Ве	thesda,	Maryland
Balt	permit. Departi Importa any inji		21. Signature of Funeral Service Licens	-	401305	Ro	Name and Address Sert A. Pur Niscons	ess of Faci nphrey	Funer	al Home/	Beth	nesda-Chev	y Chase, Inc.
Ľ			23a. Part 1. Erner the disease, or comp	lications that caused	I the death. Do					-		y1ain 2001	Approximate Interval Between
· Au	Physician		shock, of heart failure. List only o		_{10.} eatic C	ance	ar.						Onset and Death 12/13/2006
	/Medical		disease or condition resulting in death)	a	a consequence		51						12/13/2000
	Examiner		Sequentially list conditions	b									
/	p ti	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequence	of):							
¥	and I-trans	Examiner	that initiated events resulting in death) Last	C	a consequence	of):							
8760,	ficate be executed physician and s the burial-transit			500 10 (0) 40	a consequence	017.							
687	ificate g phys	edic		d									
Box	death certific e attending p id for use as	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1=					23d. Date of de	livery
0.0	0 0 0	Physician/Medical	in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnant Other (specify) _	Э				Month	Day Year
٥,	that the		Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the ur	nderlying cause giv	en in Part	1.	23e. Did	tobacco	use contribute to	o the cause of death?
Records,	The law requires that the ate has been signed by the bage 2 should be detached.	d by								1 🗆	Yes 2	2 ∑ No 3□P	robably 4 🗆 Unknown
O O	aw requir as been s 2 should	Completed								24a. Was		24b. Were a	utopsy findings available
	The law cate has page 2 a	ШО								auto perfe 1 □ Yes	psy ormed? 2 X N	prior to death?	completion of cause of s 2 □ No
Vital		BeC	25. Was case referred to medical examiner?					26. Plac	e of Death	(Check only		10 1010	2 110
	hysic this ce	2	1 Yes 2 X No		ent 2 ER/O	utpatien	t 3 □ DOA Oth	ner: 4□N	lursing Hor	ne 5□Res	idence	6 □Other (Spe	ecify)
Division of	or Attending Physician; after death. Director: After this certific in by the funeral director,	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ry 28b. y, Year)	Time of Injury	28c. Inju Wor M 1 E	ryat ′k?]Yes 2.[28d. Describe	how inj	ury occurred	
18	Attendi death. ctor: /	fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Init	urv - At home, f	arm. stre		1162 2		28f. Location	Street a	and Number or R	ural Route Number,
2	pital or Attorns after deral Direct	Certification:	4 Homicide determined	building, et	c. (Specify)		eet, factory, office			City or To			
0	Hos Fun tely	Medical	(Check only 2 Medical Exam		f examination a	nd/or in	estigation, in my	opinion, de	eath occurr	ed at the time	, date a	nd place, and du	e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	4.5			29c. Licens	se number			29d. D	ate signed (Mon	th, Day, Year)
			Nonjahell	, MD			DS	30	10		J	uly 28	, 2009
			30. Name and address of person who co	empleted cause of d	eath (Item 23a)	(Type, I	- Kens J	+	Bal	hmo	2	MD	2123/
	Sta Registra		31. Date filed (Month, Day, Year) JUL 29 2009	and manner sta	ar's Signature	aka	/						-

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Marylan		artment of H				giene Reg. No.	2111	9	24277
			Decedent's Name (First, Middle, I	.ast)						2. Date of De	ath			3. Time of Death
	Physicia /Medic		Ad	a Leala	Winds	or				Month July	25,	200	gar 9	12:05 P M
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or	Location	of Death	-	4c.	County of [Death	
1			Kensington Nursi	ng and Re			Kensin					ontgon		
	Funeral Director		5. Social Security Number 6 577–09–5814	Sex 1□M 2 X F	7. Age (In yrs. 101	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da April	$\stackrel{th}{13}, \stackrel{Year}{,} 1$		Count	ace (State or Foreign try) ginia
	pr ,		Usual Residence of Decedent										140	Na 114- O'A-11-14-
	arylar show	'n	10a. State 10b. County			ty, Town or Lo Rockvi							10	ld. Inside City Limits 1 X Yes 2 □ No
	he Ma 28a-f	Director	Maryland Montgo	nery		NOCKVI	10f. Zip Code			Т	10a Citi	zen of Wha	t Count	
	with t		10e. Street and Number				2085 1					ed St		
	ns 23	Funeral	1617 Lewis Aven	12. Was Dece	edent Ever in U	.S. 13.			rigin? (Spec			14. Race		
36	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ant, the Medical Exemprer must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Fo	rces? 2 <u>X</u> No ve	1	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🏿 No	an, Mexica Specify:		Rican, etc.)		Black, V Specify:		
9	hour atural	per			ates.	16a. Dece	dent's Usual Occup	ation			16b. Ki	nd of Busin	ess/Ind	ustry
2 1 5	e. In "ne	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	rade completed) College (1	I-4or 5+)	(Give life.	kind of work done of DO NOT use retired	during mos 1)	st of workinį	g	l			
2	d with	Son	7			Order	Processo					nting		
nd	ould be filed withir I Mental Hygiene. Parked other than Patic event, he Ma	Be	17. Father's Name (First, Middle, La							(First, Middle		Surname)		
<u>yla</u>	should I and Men s marke umatic	٩		hnson, S						Knott				
<u>a</u>	nd 2 sh ulth and 27 Is n r traun		19a. Informant's Name/Relationship Florence I. Stor			1	ng Address <i>(Street l</i> 4 Ebby Ro							
ē,	s 1 ar if Hea item 3		20a. Method of Disposition		20b. J		sition (Name of matory or other place	, ;	Da	ate		ocation - Cit		
Ē	Pages nent of int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		morial Park		July 20	30, 09	Rock	ville	, M.	aryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If lem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Signature of Funeral Service Lin	ensee /	M0130)5 Rc	2. Name and Addreso Dert A. Pun 00 West Mont	ss of Facili	ity Fumera	al Home	Rocks	ville, Marv	Inc.	20850-2805
			23a. Partil. Enjer the disease, or co	mplications that o	aused the deat							, ,		Approximate Interval Between
	hysician	ì	shock, of heart failure. List on Immediate Cause (Final disease or condition			rterv	Disease						1	Onset and Death
1	/Medical		resulting in death)		(or as a conseq	7	D100 ab							
	Examiner		Sequentially list conditions,	b	ertensi									
1	sit sed	nine	cause. Enter Underlying Cause (Disease or injury	Due to	or as a conse	Lience of it								
Or	axecul and al-tran	Examiner	that initiated events resulting in death) Last	c Due to	(or as a conseq	uence of):								
8760,	cate be executed ohysician and the burial-transit	dical E		d.										
68	rtifica ng ph as th	/ledi	IS ESTABLE							-				
Вох	eath certific attending p for use as t	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	tcome of pregnation to the come of pregnation to the come of the c		☐ Ectopic pregnanc	y				23d. Date o		ry Day Year
0	The law requires that the death certificate be executed tee has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Med	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4 ☐ Pregi 9 ☐ Unkn	nant at time of nown	death 5[Other (specify) _					WOTE		Day Ica
σ.	res that t signed by be detac		Part II. Other significant conditions	contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part	1.	23e. Did	tobacco ı	use contribu	ute to th	ne cause of death?
rds	quires an sigr uld be	ed by								1 🗆	Yes 2	□ No 3[☐ Prob	ably 4X Unknown
000	aw requir as been s 2 should	Completed								24a. Was		24b. We	re auto	psy findings available inpletion of cause of
		mo;								perf	ormed? 2 X No	dea	ith?	2 No
<u>ta</u>	ctor,	Be (25. Was case referred to medical examiner?					26. Plac	e of Death	(Check onl	one)			
5	Physician: The law r this certificate has t ral director, page 2 si		1 ☐ Yes 2 🔀 No		Inpatient 2	· · · · · ·		4 KL N		ne 5□Res			(Specif	y)
Division of Vital Records,	ding F h. After funera	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of Injury th, Day, Year)	28b. Time of Injury	Worl	yat k? Yes 2.⊑	_	8d. Describe	how injur	ry occurred		
200	Attend death ctor: y the	ficat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	be 280 Place	of Injury - At h	ome, farm, st	reet, factory, office	res ZL		8f. Location	(Street ar	nd Number	or Rura	I Route Number.
2	tal or Attendi s after death. al Director: A ed in by the fu	Certification: To	4 Homicide determine	buildi	ing, etc. <i>*(Sp</i> ec <i>i</i>	fy)				City or To	wn, State	9)		
)	of the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification properties of the funeral director, to completely filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director is the funeral director.	Medical (aminer: On the b			th occurred at the tine timestigation, in my convertigation, in my convertigation.							
	withir To th	Me	29b. Signature and title of certifier		AAA		29c. Licens					te signed (/		
	•		1 Comment		MD		D006	4624			Ju1	y 28,	20	U9
			30. Name and address of person wh							M . 7	1 (00005		
			Sandeep Sharma, 31. Date filed (Month, Day, Year)				venue, Ke	nsing	gton,	maryl	and 4	20093		
	Sta Registr		JUL 2 9 2009	Beneva	Registrar's Signa	parks								

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State of Maryland / Department of Health and Mental Hygiene 2 🔒 🦳 🔾 Certificate of Death 2. Date of Death 1. Decedent's Name (First Middle Last) 3 Time of Death **Physician** Douglas Coy Wilson 9:10P M 24. 2009 Ju₁y /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dunda1k Baltimore Co. 101 Center Place 603 Apt. 8. Date of Birth (Month, Day, Year)

July 21,1952 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. Days 1 □XM 2 □ F Yrs. Director 218-60-9101 57 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 United States Apt. 603 101 Center Place by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes No 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Never Married 2 ☐ Married ò If Yes, Give Year or Dates: 1 ☐ Yes XXNo Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Years N/A 12 Years Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 is marked of traumatic ever Robert E. Wilson Ruth E. Benton ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 2003 Denbury Drive Dundalk, Maryland 21222 Mr. Glenn E. Wilson (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 7/29/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart trillure. List only one cause or each line. Immediate Cause (Final Arterios **Physician** -and woas chap disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed are death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burnal-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 📉 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Yes 2□No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 □No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature cause of death (Item 23a)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month

Day,

21215-0036

Maryland

Saltimore,

P.O.

of Vital Records,

Division

		1 - State of Maryland / State of Maryland /		rtment of H			Reg. No.	9 21270
Physic /Medi		1. Decedent's Name (First, Middle, Last) Sarah Elizabeth Wa	amsle	У		2. Date of Dea Month July	27, 2009	3. Time of Death 5:15 A M
Exami Funeral Director	ner	4a. Facility Name (If not institution, give street and number) Montgomery Hospice Casey House 5. Social Security Number 579-09-5927 6. Sex 1 □ M 2 ☒ F 90		4b. City, Town, or Rockv If Under 1 Year Months Days		8. Date of Birt (Month, Da June 1	ıv. Year)	
70		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tou	wn or Lock				10g. Citizen of What	10d. Inside City Limits 1 🖾 Yes 2 🗆 No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its if edical Examinan mist be notified at	y Funeral Di	707 Beall Avenue 11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No		208 Vas Decedent of Hi Yes, specify Cuba □ Yes 2 \ No	50 spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	United 14. Race - A Black, W Specify:	merican Indian,
21215-0036 d within 72 hours aft giene. er than "natural", or the Medical Exmit	Completed by Funeral	3 △ Widowed 4 ☐ Divorced Year or Dates:	(Give k life. D	ent's Usual Occupa ind of work done o O NOT use retired emaker	ation luring most of work)	ing .	16b. Kind of Busine	
Maryland 2 td 2 should be filed Ith and Mental Hyg 77 is marked other rtraumatic event,	To Be C	17. Father's Name (First, Middle, Last) James Marshall Davis			Lula l	Mae Mar		
Mary nd 2 shou alth and M 27 is man		19a. Informant's Name/Relationship (Type. Print) Elizabeth Jean Bellosi/Daughter					oer, City or Town, State ach, Flori	
Baltimore, bermit. Pages 1 ar Department of Her Important: If item any Injury or othe		1 N. Burial 21 I Cremation 31 I Bernoval from State 1		ition <i>(Name of</i> atory or other plac lemoria l Pa		^{Date} 7 30,	20c. Location - City Rockville	or Town, State
Balti permit. Departi Importa any Inju		21. Signature of Funeral Service Vicensee Mighty Burket M01305	300) West Mont	gomery Aver	nue, Rock		Inc. and 20850-2805
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence)	rdial ce of): ce of):			or respiratory a	arrest,	Approximate Interval Batween Onset and Death
that the death certificate be executed that the attending physician and detached for use as the burial-transit	Physician/Medical B	d	ath 3□ h 5□	Ectopic pregnanc		M	23d. Date o Month	Day Year
rds, F quires than n signed	þ	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause giv	en in Part I.			te to the cause of death? ☐ Probably 4 🔀 Unknown
Vital Records, P.O sician: The law requires that the sertificate has been signed by the irector, page 2 should be detached.	Completed	25. Was case referred to medical			26. Place of Dea	perf 1 □ Yes	opsy prio formad? dea 2 No 1 □	e autopsy findings available r to completion of cause of th? Yes 2 □ No
Sion of tending Phy leath. tor: After this the funeral d	Certification: To Be	examiner? 1 ☐ Yes 2 💆 No	b. Time of Injury	28c. Injur Wor M 1 🗆	er: 4 🗆 Nursing H	ome 5 Res 28d. Describe	sidence 6 X Other on the how injury occurred	rSpecify) Hospice
Hospita Hospita 14 hours Funeral tely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled and manner stated.	dge, death n and/or in	n occurred at the tivestigation, in my	me, date and place opinion, death occu	e, and due to thurred at the time	ne cause(s) and manr e, date and place, and	er as stated. I due to the cause(s)
To the vithin 2 To the comple	Me	29b. Signature and title of certifier J - Koueltchou, mD		29c. Licens	se number		29d. Date signed (I	
,,,,,			Munca		1 Road,	Rockvil	le, Maryla	and 20855
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		4.3				

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ORIGINAL.

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked o any Injury or other trainment

Funeral

Director

or other traumatic event, the Medical Evan tractivust be notified at

Physician

/Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

should be det

filled in by the

Box 68760.

P.0.

Division of Vital Records,

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Jean Marie Ernst Antonisse 9:40 aM July 13, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Friends Nursing Home Sandy Spring 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Months Days Hours 1**X** M 2 □ F Yrs 79 087-32-8394 July 12, 1930 Netherlands Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2XX No Director Maryland Montgomery Sandy Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17310 Quaker Lane, C-25 Netherlands Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 120 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married Specify: White 1 □Yes 2 🕱 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Travel Executive Travel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hendrik Jacobus Antonisse Maria C. E. van der Hoeven ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cato Antonisse/Wife 17310 Quaker Lane, #C-25, Sandy Spring, MD 20860 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date July 18, 2009 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Alzheimer's Disease 1 year disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Petal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Arteriosclerosis, Sinoatrial Node Dysfunction Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🖺 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 🗷 Nursing Home 5 🔲 Residence 6 🗎 Other (Specify) 1 Yes 2X No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 🔼 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 125947 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 CHARKSVILLE MO TREKON 5540 TEN OAKS WELZE 31. Date filed (Month, Day, Year) State 15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Registrar

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State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Addison Andrew 14 2009 3:00a July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Talbot Hospice House Talbot Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day Year)

6 - 2 1 - 1 9 4 1 Birthplace (State or Foreign Country)
 MO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F 68 Yrs Director 216-38-8381 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Il Hygiene. other than "natural", or Itama 23a or 28a-1 errominent, tra Medical Examinar must be notified at Md 1 Yes 2 No Talbot Easton Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9538 Black Dog Alley C-2 21601 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 21215-0036 Specify: White 1 ☐ Yes 2 🙀 No Specify Year or Dates: Army 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Contractor Painting 8 years or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) Maryland parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lulury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Philip E. Andrew Helen Harris 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosetta Andrew Wife 9538 Black Dog Alley, C-2 Easton, Md 21601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Capitol Crematory 7-15-2009 Dover, 21. Signature of Funeral Service Licensee R. Carroll Hurley Funeral Home, PC P.O. Box 518, St. Michaels, Md. 21663

Approximate Source (Text)

R. Carroll Hurley Funeral Home, PC P.O. Box 518, St. Michaels, Md. 21663

Approximate Source (Text) 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Can Car month' **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): ettending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown anemias 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 2 No Vital Phyelcian: 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 1 ☐ Yes 2 No Certification: To ō this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 KNatural death. 1 ☐ Yes 2 ☐ No nours after death.

neral Director: A
fitted in by the for 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral D Medical 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0052255 Physiccan) TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 830 Chosalegle Dr. VA+3 Muhammad 37. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 15 2009 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend #5 Per Fital 34 Mary 2609 Department of Health and Mental Hygiene U U 9

					,	Certificate of	Death	,	Reg. No.		
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		Dorothy Mae			July		009	6:45p.m.		
	Examir		4a. Fecility Name (If not institution, giv	Abell re street end number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	_
1			Chesapeake Shor	res			Lexingto	on Park	S	t. Ma	ary's
	Funeral		5- Social Security Number 6. S	Sex 7. Age	(In yrs. last b	Months Davs		8. Date of Birt (Month, Da	h y, Yea <i>r)</i>	9. Birthp	lace (State or Foreign try)
	Director		216-14-6137	I □ M 2CRF	80	Yrs.		11/27/1	928		Virginia
	pui 🖈		Usual Residence of Decedent 10a. State 10b. County		10c City To	wn or Location				11	0d. Inside City Limits
	lanyle sho	5			•						1 ☐ Yes 2 ☑ No
	28e-1	Director	Maryland St. Ma	ary's	Le	xington Par	k		10g. Citizen of V	Vhat Coun	itry?
	with e		21478 Dana Court	_		206	5.2		US		,
	ns 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U,S.	13. Was Decedent of If Yes, specify Cut		ecify Yes or No		e - Americ	an Indian,
_	r Iter	교	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2X No	D			Rican, etc.)		k, White,	etc.
070	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify	W	hite
21215-0020	72 ho	Completed	15. Decedent's E	ducation	16	a. Decedent's Usual Occu (Give kind of work done	petion	cina	16b. Kind of Bu	siness/Inc	dustry
21	en e	npie	Elementary/Secondary (0-12)	College (1-4or 5+	+)	life. DO NOT use retire	ed)	9			
	ed wi	5	12			Homemaker			Own Hor		
pu	tal Hydrh	Be	17. Father's Name (First, Middle, Last,				18. Mother's Nam			Θ)	
yla	Men Men Barke	ဥ	Eddie Yeager				Tacy	Elyet			
Maryland	2 sh lend ls m raum		19a. Informant's Name/Relationship (•	19	b. Mailing Address (Stree					
e, l	1 end Health Im 27		John W. Abell/Sp 20a. Method of Disposition	ouse	20h Place	21478 Dana of Disposition (Name of	Court, Le	Date	20c. Location -		
Baltimore,	nt of l		1 ₺ Burial 2 ☐ Cremation 3 ☐		cemet	ery, cremetory or other pla	1			•	
Ē	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Items 23e or 28e-f show warth injury or other traumetic event, the Medical Evanting runst by northed an once.	1	4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Lic 3		Trini	ty Memorial)
Ba	Departing of the policy of the			mulas	May		ess of Facility d–Echols				
	25000		Danielle Ward	M01403	u de de De					натт	, MD 20622
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one ceuse on each line	ne death. Do e.	not enter the mode of dy	ing, such as cardiac	or respiratory e	riest,		Approximate Interval Between Onset and Death
			Immediate Cause (Final	4.1	TO	TO RAVIOL WALLOW					
1			disease or condition resulting in deeth)	a. TIETA	STAM	c Lung a consequence of):	Concep	10	DICHM	j 1	MUKIKILI
		ē			Due to (or as a	a consequence oi):					
	outed ansit	Medicai Examiner	Sequentially list conditions	b	Due to (or as a	consequence of):					
o,	an ar	EX	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events		,						
68760,	nte be nysici he bu	ical	Ceuse (Disease or injury thet initieted events resulting in death) Last								
-	ng ph as t	Med	resulting in death) East								
Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriel-transit	an		d		****					
-		Sic	Part II. Other significent conditions of	ontributing to death but	t not resulting	in the underlying cause g	iven in Part I.	23b. Did	tobecco use co	ntribute to	the cause of deeth?
P.0		by Physician/	STATUS PO	ST My	nca-	dial Fi	N FARLT	1 🗆	Yes 2□ No	3 ☐ Prol	bably 4 Unknown
JS,		5			, ,	Stof .		040 14400	en autopsy	24b W/	ere autopsy findings
Records,		Completed	Hyperte	XSION				perfo	med?	av	ailable prior to mpletion of cause deeth?
36	e law hes b	ם	1100	(1) (_			
<u>=</u>	: The		AMON H	150,16	سمم			1□`		1L	☐ Yes 2☐ No
Ζ	lclen certif recto	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Dea			(0 :	
of	Phys	5	1 ☐ Yes 2 No 27. Menner of Deeth	28a. Date of Injury	/ 28b	Outpatient 3 DOA Time of 28c. Injury			dence 6 □Oth how injury occur		<i>y</i>)
on	dIng th. Afte	후	1 Naturel 5 ☐ Pending investigatio	(Month, Day	Year)		ork? ∐Yes 2□No				
Division of Vital	Atten r dea octor	fica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Inju		farm, street, factory, office	•	28f. Location (Street and Numb	er or Rure	el Route Number,
Ö	effe Dir d in b	Certification:	4 ☐ Homicide	building, etc.	. (Ѕресіту)			City of To	vii, Siale/		
	hours hours nera iy fille		29a. Certifier (Check only Medical Exar	nysician: To the best of	my knowledg	ge, death occurred at the t ind/or investigation, in my	time, date end place,	and due to the	ceuse(s) and ma	nner es s	teted.
	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edical	опе)	end manner stat	ed.						
	Vith Tot	Σ	29b. Signature and title of dertifier)		29c. Licer	nse number	_	29d. Date signe	d (Month,	Day, Year)
	0/		Trul I	0		17/10	05 ap	2	41,5	5 3	2009
1	017		30. Name and eddress of person who	•) (Type Print) Dockser Tei	eraco Ec1	1e Chum	ch. VA	22041	
	1 0		Samuel Kleiman 31. Date filed (Month, Day, Year)		r's Signature	DOCKSEL TEL	. race, rai	Onul			
	Sta Registr		JUL 23 200		J.	barre					
	3		WW NW NW	- 100100							

09-05452 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ni-Keem Banana State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 0647 hrs Medical Examiner July 12, 2009 NIKEEM MALIK BANANA c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 14660 Hughes Road Poolesville 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** reign Country) WA Min. Months 8 Director 539-15-3599 20 JUNE 1989 1 X M 2 F Yrs Usual Residence of Decedent 10b. County 10d. Inside City Limits any 10a, State 10c. City, Town or Location 28a-f show Yes 2 No s 23a or 28a-f show e notified at once. MONTGOMERY POOLESVILLE MD be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19688 WOOTTON AVE. 20837 USA Funeral Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. tant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be Armed Forces White, etc. 1 Never Married 2 Married Yes Specify:BIRACIAL If Yes, Give Year 2 No specify: Divorced 2 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) EDUCATION 21215-0036 STUDENT 2 of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JEFFREY BANANA LISA ETHRIDGE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LISA BANANA / MOTHER 19688 WOOTTON AVE., POOLESVILLE, 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place)
STAUFFER CREMATORY Burial 2 Cremation 3 Removal from State 7/19/09 FREDERICK, MD Other Specify 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, 21. Signature of Funeral Ser ice Licensee 20838 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Head and Neck Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Exa Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical the attending physician ed for use as the burial UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death for use as past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ò Yes 2 V No 3 Probably 4 Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has death? performed? No 2 No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) funeral director, 25. Was case referred to medica Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 28a. Date of Injury (Month, Day, Year) After 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Injury Certification: Driver auto fixed object collision Jul 12, 2009 0000 hrs Natural Yes 2 V No Pending 24 hours after death. completely filled in by the To the Funeral Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 14660 Hughes Road, Poolesville, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 13, 2009 O.C.M.E. - in 30. Name and address of person who completed cause of death (Item 23a) KB

State Registrar

DHMH 17 Rev 1/2001

Assistant Medical Examiner

Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 10 Day **Physician** 2009 2:00 AM Rodger A. Bryan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice House Carroll Westminister If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Month, Day, Year 1/17/1953 Months Days 1 XM 2 □ F Riverdale MD 56 Director 212-62-2686 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Frederick Knoxville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or 21758 permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or ither any Injury or other trainment. Funeral 630 Tritapoe Drive USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify. ð Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Operator BNA - Rockville 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Wesley Bryan Edna Marie Leadman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 630 Tritapoe Drive, Knoxville MD. 21758 Carol J Bryan, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Man. Gardens 7/15/2009 Frederick MD. 21. Signatura of Funeral Service Licensee

Barbara A. Williams 22. Name and Address of Facility John T Williams Funeral Home, Brunswick MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on and line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only orde, Be Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Certification: To Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident hours after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintain as stated.

2 Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

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30. Name and address of person

31. Date filed (Month, Day,

ran

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

ENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ${\bf P}^{\!M}$ July 9, 2009 8:50 Frances Joan Baden /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F Yrs. 24, 1941 Washington, DC Director 579-54-5629 68 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Frederick Mount Airy 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ō USA 3017 White Pine Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or items 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Facility 12 Nursing Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances (NMN) Nackman Koven Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carl Richard Carter, companion 3017 White Pine Drive, Mount Airy, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 7/12/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Lee 22. Name and Address of Facility Molesworth-Williams Funeral Home Man 26401 Ridge Road, Damascus, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Fit is the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or eart failure. List only one cause on each line. Immediate Cau e (Final disease or condition **Physician** Cardio Pulmonary Arrest resulting in death) /Medical Due to (or as a consequence of) Examiner <u>Pancolitis</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Seizures that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2XINo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. **E Funeral Director:** After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, To the within 2

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, Madan Bangalore, 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

9901 Medical Center Drive, Rockville, Maryland 32 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0067512

29c. License number

29d. Date signed (Month, Day, Year)

July 10, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month July 2009 :19 DORIS LORRATNE BLATCHLEY 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick <u>Frederick Memorial Hospital</u> Frederick
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Hours Months Days Min 1 □ M 2**X** F 23, 1926 212-22-6763 83 Feb. Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 ☐ Yes 2 ▼ No Maryland Frederick Frederick 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 5819 Box Elder Court 21703 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Patrick Wyatt Pauline Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula J. Cullen - Daughter 7707 Catalpa Road, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery July 13, 2009 Mount Airy, Maryland 4 Denation 5 ☐ Other (Specify) 21. Signa ure of Juneral Service Ligensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. 20872 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intracranial remore hage Due to (or as a consequence of): coagu lopathu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to the as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No
9 ☐ Unknown Month Dav Year 5 ☐ Other (specify) 9 I Unknown use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 6 ☐ Other (Specify) y occurred

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit -transit Box 68760, nding p Division of Vital Records, P.O.

Examiner

Physician

/Medical

Examiner

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Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heath and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examination matter traumatic event, the Medical Examination matter.

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tonce.

Physician

/Medical

Baltimore, Maryland 21215-0036

Physician/Medical þ Be Completed Medical Certification: To

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				•						24a. Was an autopsy performed?	24b. Were autopsy findings ava prior to completion of caus death? 1 □ Yes 2 □ No		
ex	. Was case referred to medica			26. Place of Death							(Check only one)		
	examiner? 1 ∐ Yes 2 X No		Hospital:	1 Inpatient 2] ER/Outpatient	3 🗆	DOA Other	4 Nursing	Home	e 5 ☐ Residence 6	☐ Other (Specify)		
	Manner of Death 1 Natural 5 □ Pendi 2 □ Accident invest	ng igation		Date of Injury (Month, Day, Year)	28b. Time of Injury	M	28c. Injury Work? 1 □ Y		28d. Describe how injury occurred				
	3 Suicide 6 Could determ	not be	28e.	Place of Injury - At h building, etc. (Special		t, facto	ory, office		28	f. Location (Street and City or Town, State)	d Number or Rural Route Number		
298											and manner as stated. place, and due to the cause(s)		

29b. Signature and title of certifier

MD

29c. License number D67657

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLY

400 West 7th Street, Frederick, Maryland 21707 <u>Anish Sumant</u> Desai M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

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		-	For State Registrar	State of	f Marylan			of Health of Deat			giene Reg. No. 00	24287	
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			College View			lant birtholass	Frede		ler 24 Hrs.	8. Date of Bir	Freder		
	neral ector		5. Social Security Number 214-16-0178	6. Sex 1 ☐ M 2)② F	7. Age (In yrs. I	ast birthday) 7 Yrs.	Months [(Month, Da		Birthplace (State or Foreign Country)	
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g	Sit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Part Solution Cancer (Concerns) b. Part Solution Cancer (Concerns) c. Due to (or as a consequence of):										
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DIVISION OF For Attending Phy efter death.	d in by the funera	flca	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At he		reet, factory,			28f. Location	(Street and Number	or Rural Route Number.	
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UIVISION OF VITA To the Hospital or Attending Physician: within 24 hours effer death.	To the Funerel Dir completely filled in		29a. Certifier 1 Certifyin	g Physician: To the	best of my kno	wledge, deal	h occurred at	the time, date	and place,	and due to the	cause(s) and mann	er as stated.	
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To the within 2	000	Σ	29b. Signature and title of certifie	-A \$								Month, Day, Year)	
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, F	Sta Registr		JUL 10		eur A		Mal						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registra AMEND#3perDME, 7-15-09, BMW, MoCo Certificate of Death Rea. No. Time of Death
 1726 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year JULY 10 2009 BARTHWAL DHARMANAND 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Months Days Hours Min 1 X M 2 □ F 5, 212-51-7023 85 SEPT. 1923 INDIA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1√2 Yes 2 □ No MD. MONTGOMERY MONTGOMERY VILLAGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20719 ASPENWOOD LANE 20886 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced ASIAN INDIAN 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOV'T. DIRECTOR OF EMPLOYMENT SERVICES INDIA 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BAETHWAL KISHORI CHANDOLA SASANAND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ASPENWOOD LANE, MONTGOMERY VILLAGE, MD. 20886 VINAY BARTHWAL/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-15-2009 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 Mambella M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinc or re-piratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE 2 DAYS disease or condition resulting in death) Due to (or as a consequence of) SUBDURAL HEMATOMA 3 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CLOSED HEAD INJURY 3 DAYS Due to (or as a consequence of) FALL 3 DAYS 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No CHRONIC RENAL FAILURE 24a. Was an autopsy performe 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

certificate be executed

Box 68760,

P.0.

Division of Vital Records,

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Hospital or Attending 24 hours after death.
Funeral Director; After

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event, the Medical Examiner must be notified at

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and Mental Hygi

permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic evone.

Baltimore, Maryland 21215-0036

within 72

Director

Funeral

<u>2</u>

Completed

Be

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Examiner sician and burial-transit attending physician for use as the buria ed by the a detached fi signed by t ≥ Completed

Physician/Medical

Be

Certification: To

Medical

1⊠ Yes 2 🗌 No 27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

5 Pending investigation 6 ☐Could not be

28a. Date of Injury (Month, Day, Year) 7-7-2009 Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury 28c. Injury at Work? 1 ∐Yes 2 X No 1800

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
FALL - TRIPPED AND FELL FROM STANDING POSITION

28f. Location (Street and Number or Rural Route Number, City or Town, State) 20719 ASPENWOOD LA MONTGOMERY VILLAGE, MD

29b. Signatur

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medi¢al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

ERNEST

15 JUL

HANOWELL,



1 ☐Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA

HOME

and manner stated.

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland /		artment of F rtificate of		nd Me		giene Reg. No.?	000	21,280
			Decedent's Name (First, Middle, Last)					2.	Date of Dea	ath	V	3. Time of Death
	Physici /Medio		Sylvia Ilona B	riscoe					J	$\overset{ ext{Month}}{ ext{u} ext{1y}} 17$	7, 20	09 Year	9:00 p.m ^M
Same of a se	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	Death		4c. County of Death			
			45030 Steer Horn				Hollywoo					. Mary'	
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8	Date of Birt	h y, Year)	Cou	place (State or Foreign intry)
	Director		195-26-6963 Usual Residence of Decedent		74_	113.			(09/27/	1934	Pen	nsylvania
	yland now at		10a. State 10b. County		10c. City, To	wn or Lo	cation					T	10d. Inside City Limits
	a-f st	ctor	Maryland St. Mary'	s	Holly	book							1 ∐Yes 2 X No
	or 28 e not	Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Cou	ntry?
	23a ust b	ral	45030 Steer Horn	Neck Road			20636				Unit	ed Stat	es
	filed within 72 hours after death with the Maryland Hygiene Wher than "natural", or items 23a or 28a-f show ant, the "Medical Evaminer must be notified at	Funeral	11. Maritar States	Was Decedent E Armed Forces?		13. \	Was Decedent of F f Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specil Puerto Ric	y Yes or No- can, etc.)	. 14	 Race - Amer Black, White, 	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:	0		I∐Yes 2∭XNo	Specify:			5	Specify:	
21215-0036	tural	ed	15. Decedent's Edu		16	a. Dece	dent's Usual Occup	pation			16b. Kind	W D of Business/Ir	ite
715	in 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+	Î	(Give	kind of work done OO NOT use retire	durina most d	of working	- 4			,
212	d with giene	ĕ	Liementary/Secondary (0-12)	4		itle	Abstract	or			Real	Estate	
p	e file al Hy d othe	Be (17. Father's Name (First, Middle, Last)					18. Mother	's Name (F	irst, Middle,	Maiden S	urname)	
yla	Ment Ment arked	ဥ	Joseph Daniel Weis	S				Inci l	Hajdu				
lar	2 short and is m		19a. Informant's Name/Relationship (Ty	pe. Print)	1		ig Address (Street						•
e)	l and Health Hm 27 ther t		Janice Briscoe/Dau 20a. Method of Disposition	ghter			Steer H		ck Ro			rood, Mi	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Markel Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	1		sition (Name of natory or other plac						
莊	it. Partme		4 □ Donation 5 □ Other (Specify)		Brins		d-Echols						
Ba	Department and i	ļ, ļ,	21. Signature of Funer Street cens Edward N. Brins		мооо	- 1	. Name and Addre						
		_	23a. Part 1. Enter the disease, or compl	cations that caused t	the death. D			-		-		own, m	Approximate Interval Between
=	Physician	i u	shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line	rastal		ova.	_			,		Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a			0/0,	160	ردا برد ا	E /			6 months
	Examiner	Sequentially list conditions											
	P #	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequenc	e of):							
	ecute ind transi	Examiner	Cause (Disease or injury that initiated events	·									
ő,	oe exection of cian and cian a		resulting in death) Last	Due to (or as a	consequenc	e of):							
58760,	ficate be executed physician and s the burial-transit	edical		l									
9 ×	certifi ding se as		IF FEMALE:	3c. If yes, outcome o	of pregnancy								
P.O. Box	eath certific attending p for use as 1	Physician/M	in the past 12 months?	1 Live birth 2	2 ☐ Fetal dea		Ectopic pregnand Other (specify) _	;y			23	Bd. Date of delive Month	very Day Year
o	the d by the ached	ysi	1 □Yes 2 ☑No 9 □ Unknown	9 Unknown		0_	2 Gillol (0p00//y) _						
",	s that ned b e deta	by Pł	Part II. Other significant conditions con	ntributing to death but	t not resulting	in the ur	nderlying cause giv	en in Part I.		23e. Did to	bacco use	e contribute to	the cause of death?
ğ	quire en sig uld be	q pe	H/O Lung	Cancer					_	1□Y	′es 2□	No 3□ Pro	bably 42 Unknown
ပ္က	aw re	Completed	J							24a. Was	an	24b. Were aut	opsy findings available
ž	The la	mo								autop perfor 1 □Yes	rmęd/?	prior to co death? 1 ∐ Yes	ompletion of cause of
<u>ta</u>	sian: ertifica etor, p	BeC	25. Was case referred to medical examiner?					26. Place o	of Death (0	Check only o		1 🗆 163	2 🗆 140
>	hysic his ce I dire		1 ☐ Yes 2 ☐ No	lospital: 1 🏻 Inpatien	nt 2 ER/0	Outpatien	t 3 DOA Oth	er: 4 🗆 Nurs	sing Home	5 💢 Resid	lence 6	Other (Spec	ify)
0	ng P	on:	27. Manner of Death 1 ➡¶atural 5 ☐ Pending	28a. Date of Injury (Month, Day,	Year) 28b	. Time of Injury	28c. Injui Wor	y at k?	280	Describe h			
Sio	tend leath tor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2□N					
Division of Vital Records,	or At	Certification: To	4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, stre	et, factory, office		28t	. Location (S City or Tou	Street and n, State)	Number or Rui	al Route Number,
_	spital		29a, Certifier 1. Certifying Phys	sician: To the best of	f mv knowled	ge, death	occurred at the ti	me, date and	nlace an	d due to the	cause(s) a	and manner as	stated
	e Hos 124 h e Fur letely	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner stat	examination.	and/or in	vestigation, in my	pinion, death	h occurred	at the time,	date and p	lace, and due	to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certiful 24 hours after death. Within 24 hours after death. Within Euroratal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use at	Me	29b. Signature and title of certifier				29c. Licens	e number				signed (Month	
	0		KSUL		WD		De	5060 K	0		I	019 2	5h 2009
(1/1		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type, I	Print)					-	
	/ 4		Gurdeep Chhabra, M	.D. 23415	Three	e Not	tch Road,	Calif	forni	a, MD	206	19	
	Sta Registr	te ar	31. Date filed Jupith, Pay Year)	32. Registrar	rs Signature	base	1						
	region				1. 19	-							

1-	For State Registrar
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Reg.	No.

21291

Physi	cian
/Med	lica
Exam	ine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mudical Eventual traumatic and once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Ye the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

	1	1 - State Registrar			Certificate of Death					F	Reg. No.				
		1. Decedent's Name	e (First, Middi	le, Last)							2. Date of Dea Month				
Physici: Medic/		Mamie	Re	becca	Baker						July	20,	2009	6:55 a ^M	
Examin		4a. Facility Name (/			number)				Location of				County of Deatl		
		47659 Whe		rive				_	on Pa				t. Mary		
uneral		5. Social Security N		6. Sex 1 ☐ M 2√2 F	7. Age (In yrs.		If Under Months		If Under 2 Hours	4 Hrs. Min.	(Month, Day, Year) Country)				
irector		213-44-4		X	93	Yrs.				I A	April /	,191	6 Mary	land	
*		Usual Residence of 10a. State	10b. County	,	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
fsho	5	Maryland	ST. M	aru!c		Mechar	od o o st	<i>:</i> 11 ^						1 □Yes 2□ No	
28a-	rect	10e. Street and Nur		aly 5		Hechai	10f. Zip					10a. Citiz	en of What Co		
Sa or	Funeral Director			Corner	Rd.		20659								
ns 2	Jera	11. Marital Status			ecedent Ever in U.	S. 13. \	13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American In							rican Indian,	
in the		1 Never Marri	ed 2□ Mar	ried 1 □Ye	Forces?		fYes,speo I∐Yes :			Puerto H	ican, etc.)		Black, White		
al", c	by	3 🛣 Widowed 4 ☐ Divorced If Yes, Give Year or Dates:					i∟i Yes .	ZIANO	Specify:				Specify: I	Black	
natur Jical	Completed	15. Decedent's Education (Specify only highest grade completed)					ient's Usua kind of wo		ation uring most	of workin	7	16b. Kin	d of Business/I	ndustry	
an "	ldu	Elementary/Secondary (0-12) College (1-4or 5+)					OO NOT us	e retired))	•		_			
yyle It, th	ပိ	17. Father's Name (First, Middle, Last)					ekeep						stic Wo	rker	
dott	Be		,	*							First, Middle,	Maiden S	surname)		
narke natic	၉	Charles H. Bowman, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta													
Department or result and wenter register in them 23a or 28a-f show mortant: If them 27 is marked other than "natural", or item 27 is marked other than "natural", or item 27 is marked out any injury or other traumatic event, the Madical Evandure must be notified at once.		Ernest Baker/Son 10109 Legacy Ct., Clinton, MD 20735													
r oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City cemetery, crematory or other place) 3 Semoval from State												Town, State	
ant: I		St. Mary's Catholic Cem. Sury Charlotte Hall, MD													
y inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A.													
0 2 2 0		car	/		MO1521		30195	Thr	ee No	tch J	Rd., Ch	arlo	tte Hal	1, MD 20622	
														Approximate Interval Between Onset and Death	
sician		Immediate Cause disease or condition		_ a.	ANVGI	n red	de	me	nn	_				Years	
ledical aminer		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. A J Gn (ed demenh to Due to (or as a consequence of): Bequentially list conditions,												years	
	<u>_</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):													
nsit	Examiner	Cause (Disease or	injury	< □	acride oi).										
n anc ial-tra	Exal	that initiated events resulting in death) I	uence of):	nce of):											
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r use		IF FEMALE: 23b. Was deceden			outcome of pregna		Ectopic p	regnancy	,			2	23d. Date of delivery		
he at ed fo	Physician	in the past 12 1 ☐ Yes 2 [□No	4 □ Pi	regnant at time of d		Other (sp						Month	Day Year	
d by t etach	Phy	9 Unknown	-1			data — to all	- d - d - d - d - m -		- In Death		One Did to		a aantributa ta	the cause of death?	
igne be d	ρ	Part II. Other signif	icant conditi	ons contributing to	o geath but not rest	ating in the ur	naeriying c	ause give	in in Part I.						
	ted											es ZL]NO 3[]FI	obably 4 2 Olikilowii	
een s											240 18/00	an	24b. Were au	topsy findings available completion of cause of	
has been s e 2 should	nple										24a. Was a autop	sv			
icate has been s , page 2 should	Completed										autop		death? 1 □ Yes	2 □ No	
certificate has been s ector, page 2 should	Be	25. Was case refer examiner?						Othe			autop perfor 1 □ Yes (Check only or	sy med? 2 N io ne)	1 □ Yes	danohter's	
this certificate has been s al director, page 2 should	Be	examiner? 1 ☐ Yes 2	,No	Hospital: 1		ER/Outpatier	_		er: 4 🗆 Nur	sing Hom	autop perfor 1 □ Yes (Check only or e 5 □ Resid	sy med? 2 No ne) ence 6	1 □Yes	danohter's	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Catherine Margaret O'Toole Borges 4:45P. July2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign Country)
Pa. 8. Date of Birth (Month, Day, Year) June 22,1930 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Min. 1 M 243 K Months Days Hours Director 180-24-2741 Usual Residence of Decedent 10d. Inside City Limits show 10a, State 10b. County 10c. City. Town or Location event, the Medical Evandour noust be notified at 1X Yes 2 ☐ No Director Odenton 28a-f Maryland | Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō U.S.A. 23a 21113 #303 8603 Wintergreen Court Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 和知的 If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 'natural", or 1 ☐ Yes 2KXNo Specify: Specify: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maryland 12 Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental h Mary Anne Breslin Thomas Kilfeather ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 Is
any Injury or other trau 8603 Wintergreen Court #303, Odenton, Maryland 21113 Richard A. Borges /Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Catholic 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 7/15/2009 Bowie, Maryland
22. Name and Address of Facility Robert E. Evans Funeral Home 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Fundal Service 16000 Annapolis Road, Bowie, Maryland 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Cardiores MIA **Physician** 0 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cardiomyopathx Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23d, Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 Z No certificate 1 ☐Yes 2 ☐No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and july D0029571 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2225 E Defense they Crofton MD 21114 Berez 32. Registrar's Signature 31. Date filed (Month, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05618 State of Maryland / Department of Health and Mental Hygiene Robin Lynn Brimer Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 18, 2009 0314 hrs **Medical Examiner** Robin Lynn Brimer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury 28721 Ocean Gateway 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Country) Director MD M 2^X F Feb. 22 217-02-4953 45 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 1 Yes 2 X No s 23a or 28a-f show : e notified at once. Wicomico Salisbur Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21801 USA 28721 Ocean Gateway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 X Married Yes 2 X No White Specify: Yes 2 X No specify: Widowed If Yes, Give Year the Medical Examiner If item 27 is marked other than "natural" ≥ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. Red Lobster Laborer 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Catherine Reed event, Be Joseph Walter Munion, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 182 Oak Drive - Pasadena, Maryland 21122 Dawn Harrison/Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State July 21,09 Salisbury, MD tant; Salisbury Crematory Donation 5 Other Specify: 22. Name and Address of Facility 21 Si nature of Funeral Service Licensee Salisbury, Maryland Chapel-1213 Jersey Road 21801 Jolley Memorial Approximate Interval ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart the disease, or complications **Physician** Between Onset and failure. List only one cause on each the Death /Medical Complications of chronic alcoholism Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical 23a,27,perME, g893 7/30/09 TT **AMENDED** X UNPENDED Box 68760, 23d. Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 V Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown 2 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No ✓ Yes 2 No. 26.Place of Death (Check only one) Division of Vital 25 Was case referred to medical Be Other₄ examiner? Hospital: 4 Nursing Home 5 Residence 6 V Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: XNatural Pending Yes 2 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

32. R istrar's Signature

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

Registrar

Medical

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, Day

29d. Date signed (Month, Day, Year)

July 18, 2009

Please Type or Print in Black Indelible lpk, Ensure All Copies Are Legible.
Amend Item 20b per FH 6894 8/11/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** July Ruby Elizabeth Chaconas 8 2009 7:30/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1680 Linzee Drive Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 579-12-4010 Sept. 6, Director 89 1919 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If iten 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If "Medical Exp. ciling in until to inclind any Injury or other traumatic event, If "Medical Exp. ciling in until to inclind a 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1680 Linzee Drive 21157 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2⊠No Specify: White 2 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Talford W. Thompson Delia Alice Duncan ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Winkler / Daughter 1680 Linzee Dr. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State July 9 2009 Resthaven Crematory Frederick, Maryland 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Ent. The disease, it complications that caused the shock, or heart failure. It should not cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** Due to (as a consequence of): /Medical Examiner Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner Due to (or as a consequence of): Box 68760 The law requires that the death certificate be Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown midesu Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated. Medical completely (Check only one) 2 nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier cause of death inten 23a) (Type, Print) Alexander Bes Nu 31. Date filed (Month, Day, Year) State Registrar

09-05483 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 24294 State of Maryland / Department of Health and Mental Hygiene Charles H Clem 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1140 hrs July 13, 2009 **Medical Examiner** Clem Charles Η. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick 7611 Willow Road, Room 18 Frederick If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex **Funeral** Months Davs Hours Director Sept. 14, 1963 Country) Mary land 212-92-4842 45 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No Frederick Maryland Frederick notified at once. with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e Street and Number 21701 United States 2509 Waterside Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc Armed Forces' 1 X Never Married 2 Married 2X No Yes White after Widowed Divorced Yes, Give Year Yes 2 X No specify Specify tem 27 is marked other than "natural", traumatic event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Baltimore, MD 21215-0036 Construction Carpenter 12 nt of Health and Mental Hygiene.

It: If item 27 is marked other the other traumatic event, the Med 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Clem Patricia Burrier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Clem / Father 2509 Waterside Drive, Frederick, MD 21701 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State tant: 7/18/2009 | Libertytown, Maryland Donation 5 Other Specify: Chapel Lutheran Cem. 21. Signature of Funeral Service Licenses Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 28a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Between Onset and /Medical Death a Chronic alcoholism Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical 23a,27,perME, g893 7/30/09 TT X UNPENDED attending physician or use as the burial -AMENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ρ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? No ✓ Yes 2 No certificate Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other, Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural Yes 2 Pendina 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Pay, Year) 32. Registrar's Signature

and manner stated

Energy

Cake

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 14, 2009

Medical

State

Registra

29b. Signature and title of certifier

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First Middle Last) Day 3 Month 2009 6:00 AM 6 Louise Elizabeth Carter 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick 205 East Potomac Street Brunswick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/17/1956 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 ☐ M 2 🔀 F Brunswick MD Yrs. 215-64-2103 52 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Yes 2 No Brunswick MD Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21716 205 East Potomac Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Food Service Bruns. High School 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hazel Marie Darr Parker J. Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18514 Nathon Court, Hagerstown MD 21740 Crystal Jenkins, Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ₩ Burial 2 Cremation 3 Removal from State 6/6/2009 Brownsville MD Brownsville Heights Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee - Williams 22. Name and Address of Facility Barbara A. Williams John T Williams Funeral Home, Brunswick MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastani Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 C Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No

Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Division of Vital Records, P.O. Box 68760, ed bluods page 2

Examiner Certification; To Be Completed by Physician/Medical

2 Accident

4 Homicide

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

after death.

I Director: After this d in by the funeral d filled in by within 24 hours a Medical pletely

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Direct

Funeral

ģ

Be Completed

with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, Ita Medis 2008.

Physician /Medical

Baltimore, Maryland 21215-0036

8

Hospital

KB

State Registrar

investigation

6 Could not be

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OI 610 2. Registrar's Signature

912

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 P.O. Division of Vital Records,

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20°0°9 **Physician** JUNE 4:20 A M JOHN COOK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY COMUS 24029 OLD HUNDRED ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 5 9. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. 94 Director 363-05-9945 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show the Medical Examiner must be notified at MONTGOMERY COMUS 1 ☐Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20842 USA 24029 OLD HUNDRED ROAD by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 □Yes 2 No Specify: WHITE 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired)
BUSINESS OWNER pormit. Pages 1 and 2 should be filed within D partment of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magnetic order." Elementary/Secondary (0-12) College (1-4or 5+) RECORD SHOP 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DEMETER KUK MARY TEREBESSY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) EDWARD COOK / SON 605 CARRIAGE RD., GRANTS PASS, OR 20b. Place of Disposition (Name of cemetery, crematory or other to 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. JOSEPHS CEMETERY 6/13/09 AURORA, IL 22. Name and Address of Facility
HILTON FUNERAL HOME <u> 20838</u> P.O. BOX 86, BARNESVILLE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TWO DAYS **Physician** STROKE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ATRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 2 X No THROMBOCYTOPENIA 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Mo D31839 JUNE 5, 2009 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 CHRISTOPHER C. DUNFORD, MD 615 W. MONTGOMERY AVE., ROCKVILLE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8,2009 Physician Versacola JüÏy Iris Craig 1940 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Shady Grove</u> Adventist Rockville
If Under 1 Year | If Under 24 Hrs Montgomery
9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖫 F Florida 252-92-8777 93 9/07/ 1915 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exeminat must be notified at once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 407 Russell Ave. Apt.505 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married S (raighbaltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Georgia Lester Gus O. Spears ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 20817 8411 Irvington Ave. Bethesda, Douglass A.Craig/ Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 3 Removal from State 1 ☑ Burial 2 ☐ Cremation 7/21/2009 Decatur Cemetery Dekalb County, Ga. 5 ☐ Other (Sg 4 Donatio PHILIPADS RINALDI FUNERAL SERVICE, P.A. 21. Signature 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1∐Yes 2√xNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2 s autopsy performed 2 No 1 🗌 Yes 1∐Yes 2. No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ Medical Examiner: On the basis of examination and/or investigation in experiment. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature

31. Date fled

nd title of certifie

ddress of person who complet

of death (Item 23a) (Type, Print)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Esther Elizabeth Cornwell PM 13 2009 2:24 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) 9. Birthpiace (Country)
Sept. 30,1912 Pennsylvania If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F 96 Director 578-46-0234 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location s 23a or 28a-f show 1 XYes 2 No Rockville Director MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20852 United States 600A Veirs Mill Road within 72 hours after death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian or items 11. Marital Status the Medical Exportment Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White ð 3 Widowed 4 Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sydney Carroll Wentz Romaine Senft ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15413 Bassett Lane, Silver Spring, MD 20906 Health a Patricia Higgins/Daughter permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 1 other Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20c. Location - City or Town, State Date 20a. Method of Disposition July 14 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses DeVol Funeral Home, 10 East Deer Park Drive, Gaithersbrug, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Physician /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, Due to for esta honsequence offiif any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-trar Due to (or as a consequence of): physician Box 68760 Physician/Medical the attending properties for use as as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 XNo 4 ☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 XNo 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral o 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours a er death. ne Funeral Director: After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated To the within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 13, 2009 D0067512 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Madan S. Bangalore, M.D.,

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31. Date filed (Month, Day, Year)

32 Registrar's Signatu

9901 Medical Center Drive, Rockville, MD 20850

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	/Medic Examin				ive street and number)		- 7	4b. City, Town,	or Location o		Јиту		County of De		•••	
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9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 □ Never Marr 3 ▼Widowed	ried 2 ☐ Married 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 X If Yes, Give Year or Dates:		1	Vas Decedent of fYes, specify Cu ☐Yes 2XINo	Specify:	gin? (Speci , Puerto Ri	fy Yes or No can, etc.)		14. Race - An Black, Wh Specify: Wh	ite, etc. ite		
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Baltimore,	Pages 1 ar nent of Hea nt: If item iry or othe		20a. Method of Disposition Date Date Comment													
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	+		30. Name and add	·	o completed cause of thi, M.D.	death (Item	23a) (Type,	Print) 121	Congre	ession	nal La	ne i	Suite 4	09		
	Sta Registra		31. Date filed (Mor		2. Regist	rar's Signat	dan dan	w.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Jules S. CASS P M 2009 9:53 July 10. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1513 Sanford Road Silver Spring er 1 Year | If Under 24 Hrs. Montgomery 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1**火**□ M 2□ F 94 271-36-1255 Director Oct. 7, 1914 New York Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 United States 1513 Sanford Road by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2V No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2 □**Y**No Specify: white 3√ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Inc. once. Veterinary Medicine Veterinarian Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henrietta Schlansky Abraham Katz ပ 19a. Informant's Name/Relationship (Type. Print)
Georgeann Goldenberg, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Tanner Court, Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden 07/13/09 Falls Church, VA Torthinsky stebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 15 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 Months Immediate Cause (Final **Physician** Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy Day 5 ☐ Other (specify) □Yes 2□No Ö 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a d title of certifier July 13, 2009 D 29675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ralph V. Boccia, M.D., 6420 Rockledge Drive, Suite 4100, Bethesda, MD 20817

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 15 2009

32 Registrar's Signature

Box 68760. P.O. Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be execute After within 24 hours after death. To the Funeral Director: A

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide t 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

4+IVA RK

State Registrar

Medical Certification: To

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 Cynword by Easter mo

JUL 0 9 2009

A Selle

istrar's Signature 32. R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 8:35 p.m. Marv Loretta Cruze Julv 20. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Months Days Director 73 Maryland 217-42-0970 01/29/1936 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or Funeral 20650 United States 21585 Peabody Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify. Specify: þ 3 ₩ Widowed 4 Divorced **Black** "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Housekeeper Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Henry Chase Mary Louise Spears 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Francis X. Chase, Sr./Son 43847 Palamino Drive, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery | 07/27/2009 | Hollywood, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 K No 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 ENO 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attendir
within 24 hours after death.
To the Funeral Director: A
completely filled in by the fu death. 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

24435 Mervell Dean Road, Hollywood, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Youngsik Moon, M.D.

L 2 4 2009

			For State of Marylan		artment of F ertificate of I			2000	9 24304
			Registrar 1. Decedent's Name (First, Middle, Last)		Timodio or i	304.11	2. Date of Deat	h	3. Time of Death
	Physici /Medio		Ralph Kyle Carpenter				July	13 20	09 11:47 P ^M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of E	Death
+	-	•	E1kton Care & Rehab Center 5. Social Security Number 6. Sex 7. Age (In yrs.	last hirthday		kton If Under 24 Hrs.	8. Date of Birth		Cecil
	Funeral Director		/ 1 € 2 C 0 0 0 C	30 Yrs.	Months Days	Hours Min.	(Month, Day, Oct. 4,	Yea <i>r</i>)	Birthplace (State or Foreign Country) Tennessee
pu	>		Usual Residence of Decedent	To a sol		<u> </u>		1,20	
laryla	shov	ō		y, Town or Lo					10d. Inside City Limits 1 □ Yes 2 ☑ No
the N	28a-	Director	Maryland Cecil 10e. Street and Number	E1ktor	10f. Zip Code		11	0g. Citizen of Wha	
th with	23a ol	a D	117 Old Ferry Rd.			21921		U.S.A	. •
r deat	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	ispanic Origin? (Spe n, Mexican, Puerto I	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
3-0036 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedeal Event had to once.	by F	1 ☐ Never Married 2 ☐ Married 1 Mar		1 ☐ Yes 2 🕱 No	Specify:			White
ວ-ບບວດ 72 hours aft	atura cal E		15. Decedent's Education	16a. Dece	edent's Usual Occup	ation	T	16b. Kind of Busine	
1 thin 7	an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	e kind of work done of DO NOT use retired	during most of workir l)	ng		
led wi	her th		8	Se1	f Employe		(First Adidate A	Small B	usiness
d be file	ental l ced of	o Be	17. Father's Name (First, Middle, Last) Ralph H. Carpenter			18. Mother's Name	et M. Wi		
shout	ind M marl	ျှ	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street a	and Number or Rura			te, Zip Code)
, M	ealth a n 27 is er tra		Ralph K. Carpenter, Jr.	117	01d Ferry	Rd., Elk	ton, MD	21921	
Ses 1.	toff Fiten or oth		20a. Method of Disposition 20b. P 1 Burial 2 □ Cremation 3 □ Removal from State		osition (Name of matory or other place			20c. Location - City	or Town, State
Dallillor permit. Pages	rtmen rtant: njury		4 □ Donation 5 □ Other (Specify) Bro		w Cemeter		2009 F	Rising Su	n, Maryland
permi da	Depa Impo any li		21. Signature of Funeral Service Licensee	-	2. Name and Addres R.T. Foar 1111 S. Ou	ss of Facility d Funeral een St.,]	Home, F	P.A. Sun. MD	21911
			23 ** Part **. Enter the dis ase, or complications that caused the death shows, or heart failure. List only one cause on each line.						Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition resulting in death)	rest	ratory	_ faite	146		Onset and Death
	Medical aminer		Due to (or as a consequ	ience of):					
B		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usacs or Figury)	ience of):					
ecuted	ind transi	Examiner	that initiated events						
ificate be executed	physician and s the burial-transit		resulting in death) Last Due to (or as a consequ	ence of):					
ificate	ng phys as the	edical	d. <u>1530(152)</u>	<u>دع</u>					
th cert	attending for use as		IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal		☐ Ectopic pregnancy	i		23d. Date of	delivery
Attending Physician: The law requires that the death cert	by the at tached fo	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Ve Birm 2 □ Petal 4 □ Pregnant at time of d		Other (specify)			Month	Day Year
that i	9 8		Part II. Other significant conditions contributing to death but not resu	Iting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
quires	s been sign should be	ed by	Hypelipiclew			 	1 □ Ye	s 2 □ No 🗽	(Probably 4 ☐ Unknown
law re	2 8	Completed	CHF				24a. Was ar		autopsy findings available to completion of cause of
The	cate h	Con					perform 1 □ Yes 2	ned? deat	h? Yes 2 □ No
siclar	certificate irector, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐		at 3 DOA Othe	26. Place of Death			
g P _y	er this ereral dir	n: To	27. Manner of Death 28a. Date of Injury	28b. Time o	III 3 LI DOA	4 X Nursing Hon		nce 6 ☐ Other (3 w injury occurred	Specify)
end i	or: Aff	atio	1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury		res 2□No			
or Att	Director Director in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify		reet, factory, office	2	28f. Location (Str City or Town	reet a <i>nd Number</i> o. , <i>St</i> ate)	r Rural Route Number,
spital	r filled		29a. Certifier 12 Certifying Physician: To the best of my know	wledge, deat	th occurred at the tin	ne, date and place, a	and due to the ca	ause(s) and manne	er as stated.
he Ho	within 24 hours arter deam. To the Funeral Director: After th completely filled in by the funeral	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ion and/or in	nvestigation, in my o	pinion, death occurre	ed at the time, da	ate and place, and	due to the cause(s)
10	ZO TO TO TO TO TO TO TO TO TO TO TO TO TO	Σ	29b. Signature and title of bertifier		29c. License			od. Date signed (M	onth, Day, Year)
		-	many NO			05950		7115/0	1
100	IVA		30. Name and address of person who completed cause of death (Item		•	11.	0.1.0.5		
	Sta	te	Muhammed A. Niaz, M.D., 151 Ea 31. Date filed (Month, Day, Year) 32. Registrar's Signat	ure		ikton, MD	21921		
	Registra	ar	JUL 1 6 2009 General B.	gark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Eleanor Catherine Church 6:00 PM 12,2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisburg Rehabilitation + Nursingth ber | 6. Sex | 7. Age (In yrs. last blunday) Salisbury Year I If Under 24 His. Wicomico 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) MD (State or Foreign **Funeral** 1 □ M 2 🛛 F Days Hours Min. Months 218-24-5835 Director 80 7-3-1929 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Director 1 X Yes 2 □ No Somerset MD Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 30257 Bowland Hill Circle 21853 Funeral U.S.A. or items Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No þ Specify: Black 3X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Hamilton Doane Ellen B. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health item 27 30257 Bowland Hill Circle, Princess Anne, MD Gail Jones 20a. Method of Disposition 20c. Location - City or Town, State Bowland Hill 20b. Place of Disposition (Name of cemetery, crematory or other place) permit, Pages Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State 7/18/2009 Princess Anne, MD 4 Donation 5 Dother (Specify) John Wesley Cem 22. Name and Address of Facility 917 W. Isabella St. 21. Signature of Funeral Service Licensee Bennie Smith Salisbury, MD Funeral Home ease, or complications that caused the death. re. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Do not ente such as cardiac or respiratory arrest, shock, or heart failu Immediate Cause (Find disease or condition resulting in death) **Physician** nenet /Medical Due to h r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Day 5 Other (specify) 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has lirector, page 2 s 24a. Was an autopsy performed 1 ☐ Yes 2 No 2 No I or Attending Physician: after death.

Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital owithin 24 hours aft 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aulette Salisbury, MD 31. Date filed (Month, Day, Year) Registrar's Signat State 15 2009 Registrar

DHMH 17 Rev 1/2001

panor

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 12:25 AM July Franklin Eugene Dixon, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Frederick Iiamsville 2324 Oak Drive 8. Date of Birth (Month, Day, Year) Aug. 25, 1 Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 17♥ M 2 □ F Yrs. 1947 Maryland Director 61 218-50-2601
Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Ijamsville Frederick Directo Maryland 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code United States 21754 Funeral 2324 Oak Drive Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: White Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Maintenance Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Hahn Franklin E. Dixon, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12819 Downey Mill Rd., Lovettsville, VA 20180 Candi Dixon / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 7/11/2009 Lovettsville, VA 4 ☐ Donation 5 ☐ Other (Specify) Lovettsville Union 22. Name and Address of Fecility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1100 N. Maple Ave., Brunswick, MD 21716 23a. Part. Enter the disease: Or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Metastatic Small Bowel Cancer Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician and for use es the buriel-transit or Attending Physician: The law requires that the death certificate be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? After this certificate has been signed by the a funerel director, page 2 should be deteched in Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 🗆 No To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A investigation neral Director: A rilled in by the f 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) KB PATEL - DONNETY MD

fonth, Day, Year) 82. Registrar's Signature 8503

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 2:55am^M July 13, Katherine Louise Davis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Village Sunrise of Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 17 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6. Sex 037-20-7987 Months Days Hours Min. 1 □ M 2 1 F 76Yrs. 1932 Rhode Island Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Evarriner must be notified at Maryland | Montgomery Montgomery Village 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19429 Brassie Place, #202 20886 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify er than "natural", o Specify: 3 XWidowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "rany injury or other traumatic event, tra May once. Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alton G. Wilbur Katherine Scott 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eileen M. Shea/ Friend 209 W. Deer Park Drive, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Se vice Licen. M00689 Deer Park Drive, Gaithersburg, Maryland 20877 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or beart failure. List only one cause on each line. Immedia Cause (Final **Physician** Years Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ed by.the a 1 ☐ Yes 2 X No Ö 9 Unknown ۵ The law requires that signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2 No 1 ☐ Yes 2 X No 1 ☐ Yes Physiclan: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Living Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this (Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural ours after death.

ieral Director: Af
filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Toseph 10 D32407 July 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty, M.D., 9707 Medical Center Drive, #300, Rockville, MD 20850 3. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 15

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 17 **Physician** Arlene Dick 2009 Ju1y 12:15 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/24/1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Hours Min. 1 ☐ M 2 🖫 F Months Days 81 Yrs. 384-22-1302 Director Michigan Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2 X No Director <u>Maryland</u> St. Mary's Great Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 22252 Hemlock Way 20634 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: , or 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 21K No Specify. þ Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Etta Frysinger Heffner Lonnie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once. Karen Dick/Daughter 6509 Killarney Street, CLinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Brinsfield-Echols 07/19/2009 Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Shawn Aylesworth M01521 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Immediate Cause (Final UV cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) burialattending physician for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Dunknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? Yes 2 No Vital 1 ☐ Yes 2 ☐ No 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deat Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani Shah, 22650 Cedar Lane Court, Leonardtown, MD 20650 M.D.31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 21 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 **Physician** 1520 Margaret Lee Dove /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbo Easto memorial If Under 1 Year 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🕹 F Days Hours Director 220-32-8434 72 Sept.30, 1936 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 United States Funeral 530 W. 6th Street 12. Was Decedent Ever in U.S Armed Forces? 1 __Yes _ 2 ZNNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. In 77 is marked other than "natural", or ite 1 Never Married 2 Married If Yes, Give Year or Dates: 1 □Yes 2 No Š Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman Scott Emma May Clark ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 & Department of Health at Important: If item 27 Is any injury or other trau once. 530 W. 6th St., Denton, Maryland 21629 William M. Dove 20a. Method of Disposition 20c. Location - City or Town, State 14 Burial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery July 13,2009 Greensboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of unetal Service Licensee Fleegle and Helfenbein Funeral Home 106 W. Sunset Ave., Greensboro, Maryland leed 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cerdi /Medical consequence of) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a conse To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Hrknown has been signed by e 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Tyes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes 2 N 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? examilier: 1 ☐ Yes 2 ☐ ₩o Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 mpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No I Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a, Certifie 🔁 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of pertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

60

wash

29c. License number

plu-

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Maryland	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Type. Print)	19b. I		g Address (Street a			er, City o	or Town, Sta		ode)	
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Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Stauffe		Crematory . Name and Addres		4/2009 auffer F	Fred	lerick	, MD	ЪΛ	
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Division of Vital Records, P.O. Box	the Hospital or Attending Physician: The law requires that the death cer him 24 hours after death, him 24 hours after death, the the rest of the certificate has been signed by the attending the funeral director, page 2 should be detached for use	Completed by Physician/M	1 Ves 2 No 4 Pregr	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)					Month Day			ay Year	
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	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 X Certifying Physician: To the 2 Medical Examiner: On the ba	best of my knowledge, asis of examination and	death	occurred at the tin	ne, date and place pinion, death occu	e, and due to the	cause(s) and manne	r as stat	ted.	
	To the landstring 2. To the landstring 2. To the landstring 2.	Medical	one) and mann 29b. Signature and title of certifier	er stated.		29c. License				te signed (M			
	KB KB		P. A. A. D. A. D.	N Sha	1		56786		-Ju. Da	a la	1.3	2009	
			30. Name and address of person who completed cause	e of death (Item 23a) (T	Type, P		- 0 1 0 %)	0		2001	
	20			Ridgefield	Sui	te 104	Frederic	k,MD 21	701				
	Sta Registr		31. Date filed (Month, Day, Year) JUL 14 2009	egistrar's Signature	EL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 19, 2009 3:53 a.m. Ju₁y Carolyn Elizabeth /Medical Evans 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 41477 Miss June Court Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F Vrs Director 89 051-18-2667 09/30/1919 New Jersey Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Examinar roust be notified at 1 X Yes 2 No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 41477 Miss June Court 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 X Married 2 XNo Baltimore. Maryland 21215-0036 1 □Yes 2 No Specify. ò Specify: 3 Widowed 4 Divorced White "natural" Be Completed f Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, in Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Estelle Samuelson John L. Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. John J. Evans/Husband 41477 Miss June Court, Leonardtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/22/2009 Leonardtown, Maryland Charles Memorial 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Prince and Address of Facility Brinsfield Funeral Horn Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bi **Physician** Dreumouis disease or condition resulting in death) /Medical Due to (or as a consequence of): Cy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed page 2 No 2 No 1 ☐Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \textbf{X} Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury i Director: Ald in by the fu 1 ☐Yes 2 ☐No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, M.D. 22650 Cedar Lane Court, Leonardtown, MD 20650 31. Date filed (Month) Day, Year) State Registrar B. park

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Physician :48 am Douglas Carroll ameson 03 2009 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapoli's Arundel Medical Center Anne Arundel 8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location pormit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar D. partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modesl Expiritive 21 and the retiffied at once. 1 No 2 No Directo Pasadena Maryland Anne trunde 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21122 United States Avenue 8061 Mayer Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2.2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Erin Campbell Kimberly Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8061 Mayer Pasadena , Md. mother Kimberly 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/10/2009 Glen Burnie, Md Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ephali **Physician** minute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>م</u> 1 ☐ Yes 2 📉 o 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Empatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending in 24 hours after death.

In Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P00634 ARGELES

Registrar
DHMH 17 Rev 1/2001

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State

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Argeles

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09-05728 Larry Epps

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2009 24314

		- For State		Certific	ate of l	Death			F	Reg. No.	C. V W	J 1 10 1	
Physicia edical Examir	n/	1. Decedent's Name (First, Middle,La LARRY WILLIA		•					2. Date of Dea Month July 21, 2	Day Y	ear	3. Time of Death 2317 hrs	
		4a. Facility Name (if not institution, g Upper Chesapeake Med			41	. City, Towi Bel Air	n, or Loca	ation of Deat	n	4c. Count			
Funeral Director	- 1	210 06 2207	Sex 7. Age	(In yrs. last bii	rthday) Yrs.	If Under 1 Months		f Under 24Hr Hours Mir	_	7/1974	Foreign		
any	-	Usual Residence of Decedent 10a. State 10b. County		0c. City, Town		n				·		10d. Inside City Limits	
faryland 28a-f show	ctor	MARYLAND H 10e. Street and Number	ARFORD			10f. Zip Co	EDGEV	WOOD	1	10g. Citizen of V		1 X Yes 2 No	
th the Maryland 23a or 28a-f sho	Il Director		MEADOW WAY,			Decedent		1040	Specify Yes or N		UNITED STATES 14. Race - American Indian, Black,		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X Marri 3 Widowed 4 Divorce	12. Was Decedent E Armed Forces? 1 Yes 2	X No	If Ye		uban, Me	exican, Puert	o Rican, etc.)		nite, etc.	ACK	
2 hours af "natural"	eted by	15. Decedent's Education (Specify Elementary/Secondary (0-12)	or Dates:					(Give kind of) NOT use re		16b. Kind of	Business/In	dustry	
215-0036 be filed within 72 ntal Hygiene. rked other than ent, the Medical	omple	12 17. Father's Name (First, Middle, La			SANI	OITAT		GINEER Mother's Nam	ne (First, Middle	WAST.		AGEMENT	
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other the natic event, the Med	BeC	LARRY WILLIAM	EPPES SR		Oh Mailing	Addross (7	VIVIAN	TURNER			Zin Code)	
MD 21 d 2 should Ith and Me n 27 is man	٩	19a. Informant's Name/Relationship CASSANDRA KEEF			1309 (OLD N	ÆADO	YAW WC	, APT 3		EWOOD	, MD 21040	
Baltimore, MD 2121 pemit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	Í	20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spec		e crem	atory or oth				Date 7/29/09		·		
Baltil permit. Departm Importa		21. Signature of Funeral Service Lic	censee	kin		552 1	SCO.	PT FUN S STRE	ET. HAV	ME, P.A RE DE G	RACE.	MD 21078	
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of Vit ng Physia After this	ဥ	1 Yes 2 No 27. Manner of Death	28a. Date of Injui	ry 28	Outpatient b. Time of I	· ·	c. Injury	at Work?	28d. Describ	be how injury oc		···	
Division of Vital F the Hospital or Attending Physician: bin 24 hours after death. the Funeral Director: After this certifi upletely filled in by the funeral director,	Certification:	1 Natural 5 Pendir Investi 3 Suicide 6X Could determ	gation 7/21/09 28e. Place of Inj		225 h , farm, stree	rs		s 2 X No	28f. Locatio or Town	n (Street and Nun, State) 1910	umber or Ru	iral Route Number, City ewater Dr	
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical Cer	29a. Certifier (Check only 1 Certifying Phy	rsician: To the best of my iner:On the basis of example of example of exampl	y knowledge,	death occur	red at the ti	ime, date	and place, a	ind due to the c	Edsewood ause(s) and mare ate and place, a	nner as stat	ed.	
To the within To the comple	Medi	29b. Signature and title of certifier	and manner stated.				License r					nth, Day, Year)	
		Jellan	m)	eath /Item 22			O.C.M	.E.		July 22,	2009		
		30. Name and address of p Russell Alexander MD.	Assistant Medic			Penn St	treet, B	Baltimore,	MD 21201				
S	tate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	6-	Kil							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 3:10 P M BERNARD EIGENBRODE FOGLE July 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Center Gaithersburg Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, June 13, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 1 ₹ M 2 □ F 1920 89 June Maryland 219-07-4517 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov 1y∑Yes 2∐No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 U.S.A. 511 Russell Street Suite 617 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 □Yes 2X No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 'natural", er than "nature , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Minister Ministry of Health and Mental Hygi Item 27 Is marked other other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Grace Eigenbrode James Russell Fogle ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207B Wesley Drive, Quincy, Pennsylvania 17247-0128 Paul E. Fogle / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
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once. 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Smithsburg Crematory 7/10/09 4 □ Donation 5 □ Other (Specify) Smithsburg, Maryland 22. Name and Address of Eacility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease of complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) con gert mos. /Medical Due to (or as a cons nuence of) Examiner 6 mis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed 12 dia attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t autopsy performed certificate 1 □Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending I hours after death.

Uneral Director: A

ely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number

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State Registrar

JUL 1 3 2009

31. Date filed (Month, Day, Year)

Me

32. Registrar's Signature

mpleted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 10:30p Charles Rosser Faunce Ju₁y 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 🔯 M 2 🗆 F Months Days Hours 578-40-1581 78 03/30/1931 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 → No Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11450 Asbury Circle #315 20688 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1∐Yes 2⊑No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Steamfitter Steamfitters Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Conrad Faunce Beulah Alsop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louise Faunce/Spouse 11450 Asbury Circle #315, Solomons, MD 20688 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 4 □ Donation 5 □ Other (Specify) 07/23/2009 Cheltenham, Maryland 22. Name and Address of Facility
Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650

Founce Charles Rosser

Division of Vital Records, P.O. I	sspital or Attending Physiclan: The law requires that the de hours after death.	neral Director: After this certificate has been signed by the a y filled in by the funeral director, page 2 should be detached fi	
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Physician

/Medical

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Modical Exercity or must be notified at once.

Baltimore, Maryland 21215-0036

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cian dical	3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final isease or condition esuiting in death) a. Due to (or as a consequence of):											
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ould be det	Part II. Other significant conditions	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown										
page 2 should	<u> </u>		24a. Was an autopsy performed? 1 Yes 2 □ No 1 □ Yes 2 □ No									
director,	25. Was case referred to medical examiner? 1 ☐ Yes 2 【No	26. Place of Death (Check only one)										
d in by the funeral certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred									
d in by t	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		f. Location (Street and Number or Rural Route Number, City or Town, State)									
Medical C	29a. Certifier (Check only one) (Check only one) (Check only one)	hysiclan: To the best of my knowledge, death occurred at the time, date and place miner: On the basis of examination and/or investigation, in my opinion, death occu and manner stated.	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)									
Me	29b. Signature and title of certifier 30. Name and address of person who	29d. Date signed (Month, Day, Year) 7 18 2009										
State egistrar	David Allen, M.D. 31. Date filed (Month Pay, Year)		wn, MD 20650									
Rev 1/2001		ORIGINAL										

DHMH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Farrel1 July 2009 5:05 Wanda Gay1e 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Leonardtown 39744 Lady Baltimore Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 7, May Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F 56 Director 215-62-8593 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic event, the Medical Examinar must be notified at any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director St. Mary's Leonardtown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20650 USA 39744 Lady Baltimore Avenue Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Moonyeen Graves Wilbur Vallandingham, Sr. Joseph ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Edward Farrell /Husband 39744 Lady Baltimore Avenue, Leonardtown, MD 20650 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date July 24, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Queen of Peace Cemetery Helen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** endometrial months cana /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ icate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0055682 attending 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23,30 Moakley ST, Leonardtown, MP WILFIRSON 32. Rec strar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 **Physician** July Carl 10, 8:40 P M Victor Fleegle /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 109 W. Sunset Ave. Greensboro Caroline 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign **Funeral** Maryland 1 X M 2 □ F Months Days Hours Min. 76 1932 212-28-1767 July Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Middell Evan, in a fund by mother traumatic event, the Middell Evan, in a fund by mother traumatic event, the Middell Evan, in a fund by mother traumatic event, the Middell Evan, in a fund to the fund 1 ☐ Yes 2 No Director Florida Lee Ft. Myers 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 33908 11130 Harbour Yacht Court; 13A USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1951-55 1 □Yes 2X No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) VP Executive/Broker Insurance Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Victor Fleegle Mary Ida Noll Fleegle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health ar Patricia L. Fleegle/ wife 11130 Harbour Yacht Ct; 13a Ft. Myers, FL 33908 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery July 14, 2009 Greensboro, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, MD 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ysician and e burial-trans Due to (or as a consequence of) O. Box 68760. attending physician for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 1□Yes 2 No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 🗹 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

24 hours after death Funeral Director: within 2.

> State Registrar

Medical

29a, Certifier

one)

(Check only

29b. Signature and

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

\$ D

829 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Elinora 13,2009 Glyshko July 1:00p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2009 Tree Top Lane #11 Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Months Days Hours Min. 9/107/1923 212-47-1424 1 □ M 2 🔀 F Armenia 85 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Silver Spring 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2009 Tree Top Lane #11 20904 Armenia 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paruir Folyan Margarita Ambartsumyan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20904 Marina Glikstein/daughter 25 Featherwood Court #44 Silver Spring, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cem 7/16/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Lorent Service License Washington, D.C,. PHITTP AD RIVALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Sil<u>ver Spring,Md20910</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Anemia Due to (or as a consequence of): Liver cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension

Physician /Medical Examiner

Physician

/Medical

10a. State

MD

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Baltimore, Maryland 21215-0036

with the Maryland

burial-transit and physician the burial signed by the attending place as the detached for use as icate has been si , page 2 should t within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral Certification:

the death certificate be executed

The law requires that

Hospital or Attending Physician:

To the within 2

P.O. Box 68760,

of Vital Records,

Division

1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown

Non insulin dependent diabetes

determined

24a. Was an autopsy performed? 1 ☐ Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Tes 2 No 27. Manner of Death 1 ☑ Natural 2 ☐ Accident

29b. Signature and title of certifier

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 6 ☐ Could not be

Hospital:

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

D46364

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier

3 Suicide

4 Homicide

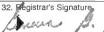
15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year) July 14,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11125 Rockville Pike #203 Rockville, Md 20852 Felix Sokolsky M.D.

State Registrar 31. Date filed (Month, Day, Year) JUL 15



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Fiease	State of	f Marylan								.egibie				
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Funeral		5. Social Security Number 6. S	ex □XM 2□F	7. Age (In yrs. 67	last birthday) Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da				ice (State o ry) ingto		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	niner: On the ba	asis of examina	owledge, deatl	h occurred a vestigation,	t the tin	ne, date and pinion, death	d place, a h occurre	and due to the ed at the time,	cause(s) date and	and manne place, and	er es sta due to	ated. the cause(s	3)	
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10+1		30. Name and address of person who	completed caus	e of death (Iten	n 23a) (Type,		-	100			·	1	-			
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Sta		31. Date filed (Month, Day, Year)	32/R	egistrar's Signa	ture!	21										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g893 7-31-09 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month

	Physician
	/Medical
*	Examiner

Funeral Director 28a-f show Director ģ Completed

traumatic event, the Medical Examinar must be notified at Pages 1 and 2 should be filed within 72 hours after death with the Inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a. permit. Pages 1 and Department of Healt Important: If item 2: any injury or other once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnarl-transit

Be

Certification: To

Medical

State

Registrar

For State Registra 1. Decedent's Name (First, Middle, Last) 3. Time of Death Jamal C. Harrell Ju1y 3, 2009 0003 Harrell Jama 1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Ft. Washington Medical Center Fort Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 6/1/66 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 1 ☐ M 2 🖾 F Days Hours Year. 577-04-9422 43 Yrs. Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 No 2 No MD Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 83 Riverside Run Dr. 20640 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Transportation Elementary/Secondary (0-12) College (1-4or 5+) Prince George's P.S. School Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hallet Lee Harrell, Jr. Bridie M. Majors ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheryl L. Harrell/Wife 83 Riverside Run Dr. Indian Head, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Neurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 7/11/09 Laurel, MD 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3831 Georgia Ave. NW Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YOLGVU ungertice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□No 1 ☐ Yes 2 Z No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred + Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1005605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Arvind Narasimhan 1171 Liingston Rd. 20744 Ft. Washington, MD 31. Date filed (Month, Day, Year)

arke

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year Billingsley Nan July 20, Hurt 2009 4:45 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 💢 F Yrs. Director 224-09-8645 90 05/16/1919 Virginia Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show r items 23a or 28a-f shoving rough be notified at Director 1 ☐ Yes 2 X No Lexington Park Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20653 45630 Roper Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🛣 No the Medical Exam ð Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Dispersing Officer Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Ment 27 is marked traumatic e Thomas Winkler Ada Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trainonce. Robert M. Hurt/Husband 45630 Roper Road, Lexington Park, MD 20b. Place of Disposition (Name of cemetery crematory or other place)
St. Andrews 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/24/2009 | California, Maryland Episcopal Cemetery 21. Signature of Euneral Service Lowsee

Edward N. Brinsf 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD Jr. 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** minutes /Medical Examiner Sequentially list conditions. Examiner Due to for as cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transi and Due to (or as a consequence of) physician s the burial Box 68760, Physician/Medical attending p for use as t IF FEMALE: asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregpant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Ö 9 Unknown 9 Unknown signed by t ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 ☐ Yes 2 No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 **T**Mo 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? or Attending 1 V Natural 5 Pending To the Hospital or Attendir, within 24 hours after death.

To the Funeral Director; A' completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D29821 20, 2009

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who comp

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LEONARDTOWN, MY

of death (Item 23a) (Type, Print)

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Exar	niner	38622 P1					40. City,	Avei		or Death		40		Mary	.1 _S	
Funer	al	5. Social Security Nur	mber 6. S	ex	7. Age (In yrs.	last birthday)	If Under		If Under Hours	24 Hrs.	8. Date of E (Month, I	irth Dav. Yea			lace (State or Foreign	
Direct		578-20-67	49	□M 2 X F	94	Yrs.	WOTUS	Days	Tiours	IVIII),	May 2	1, 1	915	Mary		
land ow		Usual Residence of D 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation				_			1	0d. Inside City Limits	
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urs aff	2	31X Widowed 4		If Yes, Giv Year or Da	re		I□Yes :	2 K No	Specify.	:			Specif	Wh	ite	
If a reference and the Maryland filed within 72 hours after death with the Maryland Hygiene. Hygiene. Wher than "natural", or items 23a or 28a-f show after than "natural", or items 23a or 28a-f show and, the Medical Examiner must be refitted at mit, the Medical Examiner must be refitted at	Completed	(Specif	15. Decedent's Ed y only highest gra	lucation de completed)		16a. Deced	dent's Usua kind of wo			st of worki	ina	16b.	Kind of B	usiness/Inc	dustry	
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ie; Mail yiallid ZIZIOOOOO stand 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. tiem 22 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, fire Mailcal Examiner must be notified at		Gilbert l	Murphy/	Nephew		P.O.	Box	45,	Aven	ue, N	Maryla					
Pages 1 nent of H ant; If iter		20a. Method of Dispo	sition Cremation 3	Removal from S		Place of Dispo cemetery, cren	sition (Nan natory or o	ne of ther plac	e)	July :	Date 25 •			City or To		
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Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director;	10			1												
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 2009 10:35 p July 12 Joseph Arlie Hopkins, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton 513 Pleasant Place If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Year Months Days 1**X** M 2 □ F 90 1919 Maryland 217-07-7746 March Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10h County 10c. City. Town or Location ral", or items 23a or 28a-f show Exemination of the notified at 1 Yes 2 □ No Director Maryland Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21601 513 Pleasant Place Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1♥Pes 2□No I*Yes, Give Year or Dates: 1941~45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 📉 No Specify Specify: White Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Police than, filed withir I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Baltimore, Maryland Eleven Years <u>Police Sergeant</u> is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Bessie May Townsend Daniel T. Hopkins ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other tra 17932 Shotley Bridge Place, Olney, Maryland 20832 (son) Joseph A. Hopkins, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Havre de Grace, Angel Hill Cemetery 07/16/09 4 ☐ Donation 5 ☐ Other (Specify) Maryland 21. Sign thre of Funeral Service License 22. Name and Address of Facility Lee A. Patterson Perryville, & Son Funeral Maryland 2190 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mo /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760. physician Physician/Medical the attending pt for use as t If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ð 1 Yes 2 No 3 Probably 4 Unknown icate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐No Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 🖪 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending I hours after death. 1 Natural 5 Pending within 24 hours after deam.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

JUL 1 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title

31. Date filed (Month, Day, Year)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Pay, Year)

09-05642 Dav

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

David Hutching		For State	of Maryland /1		tment of ificate of		and	Menta	l Hygiene	Reg. No	20	09 2132
Physician		egistrar . Decedent's Name (First, Middle,La	ast)						2. Date of D Month	Dav	Year	3. Time of Death 0129 hrs
Medical Examine	er	David Leon	Hutching						July 19,	2009	c. County of Death	
	4	a. Facility Name (if not institution, g	ive street and number)			b. City, Tov			ardtown	ľ	St. Mary's	
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with ms 23	era	1. Marital Status	12. Was Decedent E	ver in U.S	5. 13. Was	Decedent	t of Hispa Cuban, I	anic Origin Mexican, P	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame White, etc.	rican Indian, Black,
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MD nd 2 sho alth and mm 27 is	-	Rose Vinson/Mot	her	20b. F	Place of Dispos	ition (Nam	e of cem	etery,	Date		c. Location - City o	MD 20650 or Town, State
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	-	1 Burial 2 X Cremation	3 Removal from Sta		rematory or other	ner place)			07/24/20	ากด	Charlott	e Hall, MD
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Box 6876C he death certificate the attending physhed for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	ne or preg		etal death	3	Ectopic	pregnancy		Month	Day Year
x 6 th cert ttendii	icia	1 Yes 2 No 9 Unkn	4 Pregnant at	time of de	eath 5 O	ther (Spec	cify)			_		
Box he death of the attented the for us	, h	Part II. Other significant conditio	J CHRIOWII	h but not i	resulting in the	underlying	cause o	iven in Pa	rt I. 23e.	Did toba	cco use contribute	to the cause of death?
b, P.O. Be ires that the de is signed by the	by	Diabetes mellitus, hyp		~	caine u	se	,		1	/ Yes	2 No 3 F	Probably 4 Unknown
ords, I w requires us been sig	Completed	Diabetes monitor, tryp							24a.	Was an		autopsy findings available to completion of cause of
SOFC law re has be	nple									autopsy performe Yes 2	ed? death	1?
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ital	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ent 2 🗸	ER/Outpatier		OOA	Other ₄	Nursing Home	5 Re	esidence 6 O	ther:
ing Physician: The law require the seconds, After this certificate has been situreral director, page 2 should the second second the second second the second second second the second se	: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,		28b. Time of		28c. Inju	ry at Work	? 28d. Des	cribe ho	w injury occurred	
on C nding ath.	tion	1 V Natural 5 Pendii	ng FA 7/10		FD 012	29 hr	s 1	Yes 2 X				
Division tal or Attendirs after death. "al Director: Alled in by the fi	fica	2 Accident Invest 3 Suicide 6 X Could	28e. Place of Ir	njury - At I	home, farm, str	eet, factory	y, office t	building, et	tc. 28f. Loca or T	ation (Str	eet and Number of te) 45965 F	Rural Route Number, City oxchase Dr
Divisior Hospital or Attend 24 hours after death Funeral Directors	Certification:	4 Homicide determ	mined (Specify)	esid					Apt	601	Lusby, M	ID
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying Phy	ysician: To the best of m	ny knowle	dge, death occi	urred at the	e time, d	ate and pla	ace, and due to th	e cause(. date ar	s) and manner as and due to	stated. to the cause(s)
To the Hos within 24 h To the Fur completely	Medical	L. Daniel	and manner stated.	mination	and/or investig			se number				(Month, Day, Year)
	Σ	29b. Signature and title of certifier	1 . /	1	8	29		.M.E.			July 19, 2009	
		Jams	Val.	+	m 020)							
		30. Name and address of person v Zabiullah Ali, M.D. A	who completed cause of Assistant Medical E			enn Stre	et, Bal	timore,	MD 21201			
	ato	Dr. D Stad dr. att. Day Vand	32. Fegistra		ature.							
Regis	tate trar	1111 00	2009 Dener		A. Asi	alle	7					

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OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Jones 604 reid 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney Montgomery 5. Social Socurity Number General Hospital If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F Days Hours 22 Director 218-21-8522 Oct. 22 1986 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fyshology. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Laytonsville 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28904 Greenberry Drive 20882 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify: White <u>۾</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Student School 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) L. Diane Congdon Andrew ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew L. Jones / Father 28904 Greenberry Drive, Laytonsville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Metropolitan Crem. 7/13/09 Alexandria, Virginia 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home muriel Barker N. P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Presmonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypo Xemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to or as a consequence of) requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the. attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day ed by the a detached f 5 ☐ Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed? 1 □ Yes 2 ■ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has 1 ☐Yes 2 ☐ No 1 ☐Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) this မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation death. within 24 hours after death To the Funeral Director: completely filled in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 039793 mus 11,2009 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zhristopher J. Mays, MD 1811 KB. Prince Philiphilve duey, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryiand / i	•	artment of F rtificate of I		•	giene Reg. No. 7	2000	01007
	DI		Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath 6	2009	3. Time of Death
	Physici /Medio			HARRY	NEWTO	ON	KANODE		Month July	Day 7	Year 2009	4:52 A ^M
	Examir	er	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of Death	1		ounty of Death	
.48*			Frederick Memori 5. Social Security Number 6. S		al e (In yrs. last bir	rth days)	Freder If Under 1 Year		0 D-1(D)		rederic	
	Funeral Director			DM aDE	33	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Feb. 14	y, Year)	M	place (State or Foreign ntry) yland
	/land		10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	a-fsh	ctor	Maryland Freder	ick		Adaı	mstown					1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	ntry?
	ath w		5515-B Mountville			_		21710			ed Stat	es
21215-0036	a within 72 hours after death with the Maryland glene. r than "natural", or items 23a or 28a-f show the Medical Ever in act out the traiting at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:			Vas Decedent of H fYes, specify Cuba I □Yes 2⁄Ω No	lispanic Origin? (S an, Mexican, Puerti Specify:	pecify Yes or No- o Rican, etc.)		I. Race - Ameri Black, White, Specify: Wh	
15-("natu	lete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a	(Give	lent's Usual Occup kind of work done	during most of work	king	16b. Kind	of Business/In	dustry
12	filed within Hygiene. rther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	lite. L	OO NOT use retired Farmer	i)			Dairv	
	it it it	Be C	17. Father's Name (First, Middle, Last)	·			raimei	18. Mother's Nam	ne (First, Middle,	Maiden Su		
Maryland	و ق ج ق	TO E	Harry Kanode					Es	sie Ler	nhart		
lan	SP E E	Ċ	19a. Informant's Name/Relationship (g Address (Street					
	s 1 and 2 of Health a item 27 Is other trai		Barbara Kanode / 1	Wife			Mountvil					
nor	Pages 1 and ment of Healti ant: If item 27 ury or other t		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State			sition (Name of natory or other place		Date		ition - City or To	
Baltimore,	2442		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Stauff		Crematory Name and Addres				derick, neral H	Maryland
Ba	perm Depa Impo any io	_	1 ountred	Stauffer	(16	521 Oposs	umtown P	ike, Fre	ederi		
ı			23a. Part 1 Enter the disease, or companies shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do r	not ente	er the mode of dyin	ig, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
- 10	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aC	VA						-	IWK.
	Examiner		1	Due to (or ae	eensequence	of);	,					
	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	of):						
	ifficate be executed g physician and as the burial-transit	Examiner	that initiated events	c								
60,	be ex		resulting in death) Last	Due to (or as	a consequence o	of):						
68760,	icate physi s the t	edical		d								
	eath cer attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	4		236	d. Date of delive	ery Day Year
σ.	that the		Part II. Other significant conditions of	ontributing to death bu	it not resulting in	the un	derlying cause give	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
of Vital Records,	w requires that the de been signed by the should be detached	ed by	Hyperten	non					1 □ Y	es 🔀	No 3□ Prol	oably 4 🗌 Unknown
ecc	has be	Completed	UI						24a. Was a			psy findings available mpletion of cause of
<u>=</u>	ysician: The iis certificate h director, page	S							_ perfor	medi 2 No	death? 1 ☐ Yes	•
Vit	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Deat	h (Check only or	ne)		
o		2	1 ☐ Yes 2 🗷 No 27. Manner of Death	1 Inpatie 28a. Date of Injur	nt 2 ER/Ou	tpatient ime of		4 LI Nursing Ho	ome 5 Resid			(y)
on	ttending Phy death. :tor: After thi the funeral of	tio	1 Natural 5 ☐ Pending Investigation	(Month, Day		njury	28c. Injury Work M 1 🗆	res 2 □No	260. Describe II	ow injury o	occured	
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, far . <i>(Specify)</i>	m, stre	et, factory, office		28f. Location (S City or Tow	treet and N n, State)	Number or Rura	al Route Number,
:	e Hospit 124 hours e Funera letely fille	Medical (29a. Certifier (Check only one) Certifying Phyedical Exam	vsician: To the best of iner: On the basis of and manner sta	examination and	, death d/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the or	cause(s) ar date and pl	nd manner as s lace, and due to	stated. the cause(s)
ì	To th Comp	ĕ -	29b. Signature and title of certifier	00	1	1	29c. License	number	2		eigned (Month,	Day, Year)
			* Kohn x	Koup	min	h	1) D-1	13971		7/7	1/09	
	13	1	30. Name and didress of person who co							1/1	1 /	
	KB State		Robert L. Kauf		300 Trs Signature	West	9th Str	eet, Fre	derick,	MD 21	1701	
	Stat Registra	r	31. Date filed (<i>Month, Day, Year</i>)	Benera		A COLA	21					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 **Physician** C. Dorothy Ky1e July 10. 2:30 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien of Mt. Airy Mt. Airy Carroll 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours Year 1 □ M 2 XF 577-24-0747 92 20, Director July 1916West Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercities to asset the mitting once. 10a. State 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2 TXNo Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 13318 Glissans Mill Road 21771 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white <u>ک</u> Specify 3√Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Library assistant Education 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Rion Trundle Carrie Burns 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13318 Glissans Mill Road, Mt. Airy, Maryland 21771 Richard E. Kyle, II - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Stauffer Crematory 7-10-2009 4 Donation 5 ☐ Other (Specify) Frederick, MD 21. Sign due of Funeral Service Licensee 22. Name and Address of Facility Stauffer FuneralHome, PA 8 E. Ridgeville Blvd, Mt. Airy, MD 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** REKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ipital or Attending Physician: The law requires that the death certificate be executed ours after death.

ever a first death.

execution and the serviticate has been signed by the attending physician and filled in by the functer director, page 2 should be detached for use as the burish-transit sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 ☐ Yes certificate has birector, page 2 si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100059943

KB

State Registrar 31. Date filed (Month, Day, Year) JUL 13 2009

295 Registrar's Signature

30. Name and address of purcon who completed course of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Apples Are Legible.

Amend Items 14, 16acb Per Fin State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician KHUANG LTAN KAP JULY 9,2009 6:44A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 10,1947 9. Birthplace (State or Foreign Country)
Burma Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 61 Director 401-55-2695 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, INE Medical Examination must be rediffed at 1 X Yes 2 □ No Frederick Director Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21703 95 23a Blueridge Court Burma Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify. 2 Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Religious Clergy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be Thio No Nei Tial Bawi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s. Department of Health ar Important: If item 27 is any injury or other traus Blueridge Ct./Frederick, Maryland / Wife Nei Kil Lal 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Resthaven Mem.Garden | 07/11/2009 | Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/Frederick, MD 21702 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician rimari 3 maritho disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 21stan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner and burial-tran Due to (or as a consequence of): attending physician certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Dav Yea 4 Pregnant at time of death $5 \square$ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 🖟 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred or Attending 1 Matural 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0043389 30. Name and address of period who completed cause of death tem 23a) (Type, Print) Bauchmans Lane Frederick ML KB okler USCON Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

13 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 13, Girsch Kaplan 2009 /Medical 7:20 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Arcola Nursing Home Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Hours MM 2DF Months Days Min. 063-92-7061 Director 63 03/16/1946 Ŕussia Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 XYes 2 No wh the N MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Mixifical Extrainer trauss once. 901 Arcola Drive 20902 by Funeral Russia 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 🔀 No White Specify: Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Watch Maker Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Avram Kaplan ၉ Esther Shapira 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Davis, Guardian 401 Hungerford Drive, 1st Floor, Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesed Shel Emes 07/15/2009 | Capitol Heights, MD 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc.
1170 Rockville Pike, Rockville, Maryland 21. Signature of Funeral Se MO1163 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a. Acute Myocardial Infarction Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The I within 24 hours after death.

Ve the Funeral Director: After this certificate ha completely filled in by the funeral director, page □Yes 2⊠No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

Box 68760,

P.0.

Records,

Division of Vital

31. Date filed (Month, Day, Year)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D09834

July 14, 2009

20895-2110

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day July **Physician** 2009 1 Clifton B. Kuhns /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's Charlotte Hall Charlotte Hall Veterans Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 16, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 Ϊ M 2 🗆 F Pennsýlvania May 194-01-0962 94 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural" ~ ... any Injury or other traumatic event 10c. City, Town or Location 10a. State 10b. County **Funeral Director** Anne Arundel Odenton MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1308 Crawfords Court 21113 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Xes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 XNo Specify: If Yes, Give Year or Dates: 1942–45 Completed by Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Plumber 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Kuhns Zada Tyger ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifton Blair Kuhns, Jr. / 1308 Crawfords Court Odenton, MD son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donarton 5 ☐ Other (Specify) Maryland Veterans Cem. 7/10/2009 | Cheltenham, MD 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee Bowie, MD 6512 NW Crain Hwy. 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of): burial-transi Dementra and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician: The law requires that the death certificate be executed Division of Vital Records, this death. the Director:

filled in by thin 24 hours a

Certification: To

Medical

Registrar

1 Tyes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hold sufficiently find the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

2 No

ChaploTTe

Fell

Frame

5:15

10d. Inside City Limits

White

21113

1 ☐ Yes 2 No

РM

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 les 2 No

27. Manner of Death

1 Natefal

3 ☐ Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only

Home

2. No

Home

28f. Location (Street and Number or Rural Route Number City or Town, State)

performed

2-1 No

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Veterans

26. Place Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

SALVASTON 3001

31. Date filed (Month, Day, Year)

28a. Date of Injury (Month, Day, Year)

and manner stated.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) VETERMS

		1 - State Registrar	State of Maryland	•		of Hea of Dea		-	giene Reg. No.	0000	24332
		1. Decedent's Name (First, Middle, Last)						2. Date of De		· Von	3. Time of Death
Physici /Medio		Eugene Louis Kibl	.er					July :	L2 Day	2009	8:15 P M
Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, 7	Town, or Loca	ation of Death		4c.	County of Death	
		12539 Greensboro Ro				nsbor				Caroline	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. In	ast birthday) Yrs.	If Under Months		Under 24 Hrs. ours Min.	8. Date of Bir (Month, Da	a <i>y, Year)</i>	Coun	
Director		Usual Residence of Decedent	79	113.				Dec. 23	3 192	29 Mary	land
and		10a. State 10b. County	10c. City	, Town or Loc	cation					1	0d. Inside City Limits
Mary -f sh	to	Maryland Caroline	Cr	eensbo	ro						1 □ Yes 2 🖔 No
the	Director	10e. Street and Number		CCIIDDO	10f. Zip	Code			10g. Citi	izen of What Coun	itry?
3a o	<u>E</u>	12539 Greensboro R	load		2	1639				USA	
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es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatic e		20a. Method of Disposition	20b. P	ace of Dispos	sition (Nam	e of		Date		ocation - City or To	
permit. Pages 'Department of Important: If ite any Injury or of Once.		1 XBurial 2 ☐ Cremation 3 ☐ Ren	noval from State	emetery, crem y Cross	-		T21 1 77	17 200	a c	raanahar	o, Marylan
artme ortan Injur		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	JIIOT.			d Address of		17 204	<i>y</i> G	reenspor	o, maryian
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Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	lence of):		9100					XUPS.
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ding p	0	IF FEMALE:	Maria a danaga danaga						-1		
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the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	eatn 5∟	Other (sp	ecity)					,
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Phy er this eral d	. To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of		Bc. Injury at Work?	Nursing Ho	28d. Describe		6 ☐ Other (Specific occurred)	<u> </u>
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al or s afte al Din	Certification:	4 Homicide	building, etc. (Specify	′)			Į.	City or To	wn, State	*)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		(Check only 2 Medical Examine	ian: To the best of my known: On the basis of examinations	wledge, death	occurred vestigation	at the time, d	date and place, on, death occur	and due to the	e cause(s	and manner as s	stated. the cause(s)
To the H within 24 To the F complete	Medical	one)	and manner stated.								
5 4 kj.		29b. Signature and title of certifier	***		290	License nur	noer	,	29d, Da	te signed (Month,	Day, rear)
		10-11				D 30	188			1.15	.09
		30. Name and address of person who com	111 50	1	Print)	D	a) a #	201	5,	other h	21211
4 Ct-	to.	31. Date filed (Month, Day, Year)	32 Registrar's Signat		eal	1)	rive	W)	Cla	2101	1100160
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DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last Annabelle Mary Klunk **Physician** 2000 20 /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TRACE C1512ENS NURSING Homs 8. Date of Birth (Month, Day, Ye April 8 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year) 916 5. Social Security Number 162-07-0090 **Funeral** Days 93 Ponnsylvania Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland nent of Health and Mental Hyglene. And the them 27 is marked other than "natural", or Items 23a or 28a-f show ant; if Item 27 is marked other than "natural", or Items 23a or 28a-f show ant; Ite Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Maryland Harford Havre de Grace 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United Statesof America 21078 1104 Lapidum Road by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Family Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Ida Kruedler 17. Father's Name (First, Middle, Last) Martin L. Knaper Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; if Item 27 is any Injury or other trau once. 1104 Lapidum Road. Havre de Grace. Maryland 21078 William Klunk (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gdns 07/24/2009 Aberdeed. Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Zellman Funeral Home. P.A. 21. Signature of Funeral Service 123 S. Washington St., Havre de Grace, Maryland or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the dise shock, or heart fail Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 Physician /Medical Due to (or as a conse pence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 9 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation within 24 hours are: ____ To the Funeral Director; Aft 1 🗌 Yes 2 Accident 6 Could not be determined 28e. Place of injury At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 120109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Evolution St-HDG. MD 21078

State Registrar

DHMH 17 Rev 1/2001

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32. Registra s Signature

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Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - State Registrar 1. Decedent's Name (First, Middle, L		Ce	ertificate of			eg. No. 4 UU 9	2 4 3 3 . Time of Death
· Parish	Physic /Medi Exami	cal	Lewis Lee 4a. Facility Name (If not institution, g	ive street and number)	4b. City. Town, o	r Location of Deat		2009 Year 4c. County of Death	3:10 a. M
March	LAGIIII	ici	Northampton			Frede	rick		Frederick	
	Funeral Director		212-14-6588	Sex 7. A	ge (In yrs. last birthday 91 Yrs.	Months Days	If Under 24 Hrs Hours Min.		9. Birth Con 1917 Mary	nplace (State or Foreigi Intry) land
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Freder	ick	10c. City, Town or L					10d. Inside City Limits 1 □Yes Ž No
	th with the 23a or 28 ust be not	ral Director	10e. Street and Number 7802 Fingerboa	ırd Road	1	10f. Zip Code 21704	,	10	og. Citizen of What Cou USA	untry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantural and to notified at once.	by Funeral	11. Marital Status 1XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 TYes 2 If Yes, Give Year or Dates:	Ever in U.S. 13 No	. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☑No	lispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:	
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Baltimore, Maryland 21215-0036	Pages 1 a transmitted that the transmitter that the transmitter tr		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec			osition (Name of ematory or other place 1 Cemeter			Poc. Location - City or Trederick,	
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	Physician /Medical Examiner) i	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as	d the death. Do not er ne.		ng, such as cardiad	c or respiratory arre	est,	Approximate Interval Between Onset and Death
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	the death certi y the attending ched for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of deliv	very Day Year
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אוומו חפכסום	tn: The law I	Completed	25. Was case referred to medical	F					prior to conded? death? 1 □Yes	opsy findings available ompletion of cause of
	In the hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	ition: To Be	examiner? 1 Ves 2 No 27. Magner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ent 2 ER/Outpatie ury 28b. Time o lnjury	of 28c. Injur Work	er: 4 Nursing H	ome 5 Resider 28d. Describe how	nce 6 Other (Spec	ify)
IDISIAID.	ital or Atter	Certification:	3 Suicide 6 Could not be determined	building, et	ury - At home, farm, st c. (Specify)			City or Town,		
:	the hosp thin 24 hot the Fune mpletely fit	Medical	one) edical Exa	hysician: To the best miner: On the basis of and manner st	if examination and/or ii	nvestigation, in my o	pinion, death occu	irred at the time, da	use(s) and manner as ite and place, and due	to the cause(s)
)	vit oor	~	29b. Signature an Male of certifier			D 60	6 LLZ 3	29	d. Date signed (Month, $\frac{1}{2}$ $\frac{1}{8}$ $\frac{1}{8}$	Day, Year)
	KB			LARUM,	leath (Item 23a) (Type,	TJ OLI	UE, FR	EOGNICE	7/8/09 k, MD -2	1702
	Sta Registra		31. Date filed (Month, Day, Year)		ar's Signature	Kel				

			For State Registrar	State of N		d / Dep		t of H	lealth a				e _{2 0}	09	243	35
	Physici		1. Decedent's Name (First, Middle,	,		A TAT					2. Date of D Month JULY	eath	ay	Year 009	3. Time of D	
and the second	/Medic Examin		FRANCES LOI 4a. Facility Name (If not institution, FREDERICK MEI	give street and numbe		AIV		Town, or	Location o	of Death	00111	4	c. County	of Death		
	Funeral Director		5. Social Security Number 218-38-2208			last birthday, Yrs.			if Under Hours	Min.	8. Date of B (Month, I March	Day, Yea	r)	9. Birth Cou	place (State or intry) ryland	Foreign
	ne Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Frede	erick		y, Town or Lo	/ille				:	406	Nu		10d. Inside City	
	ath with the 23a or 2		10e. Street and Number 17004 Sabillasvi				10f. Zip	21	780			U	nited nited	l Sta	ates	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if it. Medical Examination interior must be rediffied at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Deceder Armed Forces d 1 □ Yes 2 5 If Yes, Give Year or Dates	s? ☑ No	S. 13.	Was Deced If Yes, spec 1 □ Yes		ispanic Ori in, Mexicar Specify:		ecify Yes or N Rican, etc.)	lo-		k, White,	ican Indian, etc. ite	
21215-0036	within 72 ho iene. • than "natur fre Medicel	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2		r 5+)	(Give	edent's Usua kind of wor DO NOT us Homema	rk done d se retired	ation during mos l)	t of work	ing	16b.	Kind of Bu	Home		
land 2	uld be filed Aental Hyg rked other tic event, t	To Be C	17. Father's Name (First, Middle, La Guy Butts	ast)							e (First, Middi	le, Maide		-		
Mary	nd 2 shou alth and M 27 is mai er traumai		19a. Informant's Name/Relationship Michael Leathern								eld, P	_			ip Code) 17320	
Baltimore, Maryland	Pages 1 a ment of He ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	□ Removal from Statecify)	(e	Place of Disponentery, creating			i		Date 3/2009			•	own, State Maryla	ınd
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Li	MAN	N	10	521 Op	osst	untow	n Pi		eder	ick,	Mary	yland 2	
***	Physician /Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	aa.	line.	hal .				cardiac	or respiratory	arrest,			Approximate Interval Betw Onset and De	een/
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	ridus as a conseq	15										
,092	te be executed ysician and e burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or a	as a conseq	uence of):									-	
Box 687	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d23c. If yes, outcon	n 2 ☐ Feta	I death 3	⊒ Ectopic p		y				23d. Dat	te of deli		ear
, P.O.	that the de ned by the a detached f	y Physic	1 ☐ Yes 2 ☑ No g ☐ Unknown Part II. Other significant condition		n		Other (sp		en in Part I		23e. Did	tobacco	use contr	ribute to	the cause of de	eath?
ecords	sician: The law requires tha certificate has been signed rector, page 2 should be del	Completed by	Probetre M	rllitus	-			17			24a. Wa				obably 4 Ui	
ital R	cian: The ertificate h	Be Com	25. Was case referred to medical examiner?							e of Deat	per 1 □ Yes h <i>(Check only</i>	formed? 2 🖅	_ 0	death?	2 □No	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	ပ	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of In (Month, I		ER/Outpatie 28b. Time o Injury		8c. Injur Work	v at		ome 5 ☐ Re 28d. Describ				ify)	
Dİ <u>Vİ</u>	ital or Att urs after de ral Directe	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ed 28e. Place of building,							City or T	own, Sta	ite)		ral Route Numb	oer,
	the Hosp hin 24 hou the Fune mpletely fi	Medical	(Check only 2 Medical Ex	Physician: To the be kaminer: On the basis and manner	of examina		nvestigation	, in my o	pinion, dea			e, date a	nd place,	and due	to the cause(s)	
)	-		29b. Signature and the of certifier	ha complete d	f doctil (1)	20c) /T			0 6 3	49	8	23U. L		109	, Day, Year)	
K	B 4 Sta	ite_	30. Name and address of person with the condition of the	10. 1.10.11.	1.16 1	00 11	. 7.1	St	reet,	Fre	derick	, <u>Ма</u>	ry1ar	nd 2	1701	
DHI	Registr	ar	JUL 13 20	33. Regi	n A		GINAL									

Baltimore, Maryland 21215-0036 Dearmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan

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			Plea	se Type or I							_		_egible	•		
	-	For State Registrar		State of	ıvıaryıar	•	artment <i>rtificate</i>		lealth and Death	went		giene Reg. No.	200	9	243	35
		1. Decedent's Name	e (First, Midd	le, Last)							ate of Dea	ath			3. Time of De	eath
Physicia		Eugene	Lawso	n, Sr.							ionth	Day	1 200	59	4:51	M
/Medica Examine		4a. Facility Name (/	If not institutio	n, give street and nur					Location of Dea		Ou / C	4c. (County of De			
<i>*</i>				County Hos			Hage						shingt			
Funeral		5. Social Security N		6. Sex 1 X M 2 ☐ F	7. Age (In yrs		If Under Months	1 Year Days	If Under 24 Hrs Hours Min	i. (A	ate of Birt Nonth, Da	th y, Year)		Country		oreign
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and w	ŀ	10a. State	10b. County		10c. C	ity, Town or Lo	cation							10d.	Inside City	Limits
Maryl f sho	ğ	Maryland	Wash	ington		Hagers	town								1 □ Yes 2	X No
r 28a	Director	10e. Street and Nur	mber				10f. Zip	Code				10g. Citiz	en of What	Country	?	
pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D partment of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Expansion must be notified at one.	<u>a</u>	424 Vill	age Pl	ace			217	42				USA				
ms 2	Funeral	11. Marital Status		12. Was Dece	dent Ever in U	J.S. 13.	Was Deced	ent of Hi	spanic Origin? (n, Mexican, Pue	Specify Y	es or No	- 1	4. Race - Ar		Indian,	
after or ite	3	1 🔲 Never Marri	ied 2 🛣 Mar	ried Armed Fo	2 No		ii res,sped 1 ∐ Yes 2		Specify:	no nican	i, eic.)		Black, WI	whi	te	
ral",	ğ	3 Widowed	4 Divorced	If Yes, Giv Year or Da	ates:		1 1 1 6 5 2	140	ореспу.				Specify:	WILL		
72 hd natu	Completed	(Spec	15. Deceder	nt's Education		16a. Dece	dent's Usua kind of worl	Occupa done d	ation <i>furing most of wo</i>	orking	- 10	16b. Kir	d of Busines	ss/Indus	try	
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ed w lygier rer tl	ဂြ ပ			3		Chier	Opera	ting	g Office				Medica	11		
be fill d oth even	Be	17. Father's Name							18. Mother's Na		it, Middle, Ferr		Surname)			
2 should be n and Mental is marked or raumatic even	0		liam L													
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and lealth m 27 her tı	-	Betty Law		wite				<u> </u>	lace, Ha		COWD				1742	
Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disp	•	3 Removal from		Place of Dispo cemetery, crei				Date			cation - City			
. Pag tmen tant: jury		4 ☐ Donation	5 ☐ Other (S	Specify)	Mt.	Olive			1	L -20 0					ryland	i
permit. D partir In porta any inje		21. Signature of Fu	uneral Service	Livensee -					ss of Facility St							
<u>~</u> □ = @ Ø		Bhur	DW (amelle	COL				umtown I				ck, Ma			21702
	-	23a, Part 1. Enter t shock, or hea	the dise e, o art failure. List	r complications that c t only one cause on e	aused the dea ach line.	th. Do not en	ter the mode	of dyin	g, such as cardi	ac or res	piratory a	rrest,		l lr	pproximate terval Betwe nset and De	
Physician	Î	Immediate Cause disease or condition	(Final	Hear	t for	line	review	,	sessis						nset and De	alli
/Medical		resulting in death)		Due to (or as a conse	quence of):	1012									
Examiner	.	Sequentially list co.	nditions	b. Lu	mg	non										
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ecute and trans	am	Cause (Disease or that initiated events	injury S) c#4	not fil	sillet	16-									
e exe		resulting in death) !	Lasi	Due to (or as a conse	quence of):										
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eath certific attending p for use as 1	Mec	IF FEMALE:														
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e deg	SICI	1 ☐ Yes 2 [□No	4 ☐ Pregr 9 ☐ Unkn	nant at time of own	death 5	Other (sp	ecify)					WOTH		<i>a</i> y 10	ur
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law nas b	ble									. 2	24a. Was autor				y findings av letion of cau	
sician: The law certificate has b rector, page 2 s	Completed									1	perfo I∐Yes	rmed?	death	1?	□No	
or Attending Physician; ifter death. Director: After this certifica in by the funeral director, p	Be	25. Was case refer examiner?	red to medica	ıl					26. Place of De	eath (Che	eck only c					
Physic this co	0	1 Yes 2 X] No	Hospital:	npatient 2	☐ ER/Outpatie	nt 3□DO	A Othe	er: 4 ☐ Nursing	Home	5 ☐ Resi	dence 6	Other (S	pecify)		
ding Ph h. After th funeral	ü	27. Manner of Deat	th 5 ☐ Pendir	28a. Date	of Injury th, Day, Year)	28b. Time o	f 28	Bc. Injury Work	y at c?	28d. [Describe I	how injury	occurred			
endin ath. or: A	ا ۼ	2 Accident	invest	gation			М		Yes 2□No							
er de recto	≅	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	.: 28e, Place	of Injury - At I	nome, farm, str	eet, factory,	office			ocation (Rural F	Route Numbe	∋Γ,
tal o rs aft al Di ed in	Certification:															
	edical	29a. Certifier (Check only		ng Physician: To the Examiner: On the b	asis of examin											
the the mple.	Med	one) 29b. Signature and	I title of cortific		ner stated.		200	Licence	e number			29d Dat	e signed (Mo	onth De	v. Year)	
5.≥ 5 8 8 8	-	Lab. Orginature and	Auto or certific	" De e	ul.							_ou. Dat			,, . Jui/	
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State Registra		JL	1107	2009 Les	un p	1. 100	18 S			`						

			Please 1 – For 1 – State Registrar	State of	Print in E f Marylan	id / De		t of H	ealth a		Mental Hy		ible. 09	24337
			1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea		Year	3. Time of Death
A.	Physici /Medic		Sen How Lee								July 1			5:25 a M
	Examir		4a. Facility Name (If not institution, g Montgomery Hosp		ey House		R	ockv:					tgom	
	Funeral Director		5. Social Security Number 6. 578-72-6451	Sex 1 □ M 2 ☐ F	7. Age (In yrs. 87	last birtho	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da March 6	v. Year)	Cou	place (State or Foreign ntry) ina
	e Maryland a-f show	ctor	Usual Residence of Decedent	Montgome		ty, Town o	or Location Olne	у		_				10d. Inside City Limits 1 □Yes 2 █️No
	h with the	al Director	10e. Street and Number 17 Megans Cour	t			10f. Zip	Code 0832				10g. Citizen of USA	What Cou	ntry?
920	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "natural", or items 23a or 28a-f show event, if a Modicil Exaction trinst to notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Fo	2 🔼 No ive	.S.	13. Was Dece If Yes, spe 1 □ Yes	cify Cuba	spanic Ori n, Mexicar Specify:	gin? (Sp	ecify Yes or No Rican, etc.)		ick, White,	can Indian, etc. ian
215-0	ithin 72 hou ne. nan "natura I Medieni 1	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (((ecedent's Usu Give kind of wo ife. DO NOT u	al Occupa ork done o se retired	ation Juring mos)	t of work	ing	16b. Kind of E		
d 2	I Hyg other ent, I	Be	17. Father's Name (First, Middle, La. K. S. Lim	st)		C	wner			e (First, Middle, Chu Lau	-		ervices	
Maryl	nd 2 should be fi alth and Mental I 27 is marked of r traumatic ever	ပ္	19a. Informant's Name/Relationship Shuet Jin Lee/Da								ney, MD	er, City or Town, State, Zip Code) 0 20832		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 12 Drawler 2 Cremation 3 4 Donation 5 Other (Special Content of Cont		State	cemetery,	isposition (Na crematory or o	ther plac		July	Date 7 18,	20c. Location	-	own, State Maryland
Balt	permit. Departr Importa any Inje		21. Signatura of Funeral Service Lic	1-Cola	2		22 Name a Franc	d Addres		lins	Funera			ng, MD 20901
	Physician /Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. A	caused the deat each line. cute Cen (or as a consec	rebro	vascul				or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner parsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	(or as a consec	quence of)	:	-				<u> </u>		
68760,	rtificate be executed ng physician and as the burial-transit	-	resulting in death) Last	Due to	(or as a consec	quence of)	: 							
O. Box 6	The faw requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 🔲 Live	itcome of pregn birth 2 ☐ Feta gnant at time of nown	al death	3 ☐ Ectopic 5 ☐ Other (s		/				ate of deli	very Day Year
rds, P.	quires that in signed build be deta		Part II. Other significant conditions Hypertension	s contributing to c	leath but not res	sulting in the	he underlying	cause give	en in Part I					the cause of death?
of Vital Records,	sician: The law requir certificate has been s irector, page 2 should i	Completed by									24a. Was autop perfo	osy ormed?	prior to c death?	topsy findings available ompletion of cause of 2 No
Vita	Physician: The riths certificate in this certificate in all director, page	Be	25. Was case referred to medical examiner?	Hospital:				OA Oth	or:		th (Check only o			
	ing Phy After this uneral d	ion: To	1 ☐ Yes 2 🛣 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date (Mo.	Inpatient 2 e of Injury oth, Day, Year)	28b. Tir		28c. Injur Work	4 🗆 N		ome 5 Resi	dence 6 30	- ' '	Hospice
Division	r Attenter death	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine		e of Injury - At h ling, etc. (Speci	ome, farm			.,,		28f. Location (City or To	Street and Nun wn, State)	ber or Ru	ral Route Number,
	Hospita 4 hours uneral ely filled	Medical Co		Physician: To th aminer: On the and mai										
	To the within 2. То the р	Me	29b. Signature and title of certifier J-12011000000000000000000000000000000000	hou	, mo				e number	8		29d. Date sign		n, Day, Year) 12, 2009

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUL 15 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou, MD 1355 Piccard Drive, #100, Rockville, MD 20850

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 07 05 Day **Physician** Crawford Lee Leitch 11:38a M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Caroline 613 S. 5th Ave. Denton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 213-60-9652 M 2 ☐ F 56 04/03/1953 MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ltem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD Talbot Easton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 USA 27039 Presquile Road death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status ifiled within 72 hours after d I Hygiene. other than "natural", or Item Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working jite. DO NOT use retired)

Hydrographics Engineer Dept. of Natural Elementary/Secondary (0-12) College (1-4or 5+) Resources 12th Health and Mental Hygie Iem 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Franklin Crawford Leitch Lola Leitch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beverly Leitch/Wife 27039 Presquile Rd. Easton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
LLC Directematory 20c. Location - City or Town, State Dover, Delaware 20a. Method of Disposition 07-13-09 Department of H
Important: If Ite
any injury or ot
once. Dover, 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home 21. Sign that of Funeral San ice License 426 Dover St. Easton, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset, and Death Immediate Cause (Final **Physician** mas disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 1 Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 은 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Man er of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

Registrar

State

TLS

David

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

For AMEND#19A per FH State of Maryland / Department of Health and Mental Hygiene State Registrar 7/16/09 AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July y 10^{ay} 2ďÔ'9 01:15 Ам Alice Diana Long 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel La Casa Assisted Living Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/30/1929 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Months Days Hours Min. 1 □ M 2√□ F 80 Yrs. Washington,D.C. 10d. Inside City Limits 1 □Yes 2 No 10g. Citizen of What Country? United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Specify: White 16b. Kind of Business/Industry Home 18. Mother's Name (First, Middle, Maiden Surname) Rose Malatesta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Coxswain Way, #202, Annapolis, Maryland 21401 20c. Location - City or Town, State 07/15/2009 Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 7-10 DAYS 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2NO No 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \bigcirc Other (Specify) Assisted 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Nwoe prochimer and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier R086053 07/10/2009 daress of person who completed cause of death (Item 23a) (Type, Print) Jane Schramek 213 Newport Drive, Severna Park, Maryland 21146

Physician

Examiner

Funeral

Director

/Medical

579-32-9587

31. Date filed (Month, Day, Year) State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ju1v10^{Day} 200^{Yea} **Physician** Fear Lister P Margaret /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Denton 405 Carter Ave. 7. Age (In yrs. last birthday) 86 vre If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Nov. 22, Birthplace (State or Foreign Country)
 MD Social Security Number 6. Sex **Funeral** 218-16-6643 Months Days 1 □ M 2 X F Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County l Hygiene. other than "natural" or items 23a or 28a-f show rent, the Medical Examiner must be notified at 1 XYes 2 No MD Denton Caroline Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21629 405 Carter Ave. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner ministration. by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Specify: Caucasion 1 □ Yes 2 No Specify 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) service businesswoman Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Fear John Aloysius McKenna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Carter Ave., Denton, MD 21629 James H. Lister, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/12/09 Dover, DE Capitol Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Moore Funeral Home, P.A., 12 S. Second St., Denton, MD 21629 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Septicarmia 945 Due to (or as a consequence of) leek ected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of)

Physician /Medical Examiner

with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

dical Exam	that initiated events resulting in death) Last	Due to (or as a consequent	ience of):			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown	death 3 ☐Ectopic			23d. Date of delivery Month Day Year
	Part II. Other significant conditions	contributing to death but not resu	Ilting in the underlying	cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
ed by	Dementia		<u></u>		1 ☐ Yes 2[□ No 3 □ Probably 4 □ Onknown
Completed					24a. Was an autopsy performed? 1 Yes 2 XVo	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ Yo
Be (25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
일	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ [OOA Other: 4 Nursing	Home 5 Residence	6 □Other (Specify)
	27. Manner of Death 1 ▼Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
Certification	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		me, farm, street, facto	ory, office	28f. Location (Street and City or Town, State	d Number or Rural Route Number,)
ical		nysician: To the best of my kno miner: On the basis of examina				

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

JUL 1 3 2009

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Vaidyanathan Lakshmi, M.D., 219 South Washington Street, Easton, Maryland

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland		rtment of Health and tificate of Death		ene g. No.?	21311
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dav Year	3. Time of Death
and the same	/Medic		Rita Catherine May 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deal		4c. County of Death	7:50 A M
~	Lamin		Washington Co. Hospital		Hagerstown		Washingt	on
١	Funeral Director		5. Social Security Number 6. Sex 1 → M 2 🖾 F 7. Age (In yrs. Ia 72	a <i>st birthday)</i> Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		7ear) 9. Birthp Cour MI	lace (State or Foreign atry)
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation		1	0d. Inside City Limits
	e Mary Ba-fsh	ctor	MD Frederick		Myersville			1 □Yes 2X No
	with th	Funeral Director	10e. Street and Number 10234 Church Hill Rd.		10f. Zip Code 21773	10	g. Citizen of What Coun	try?
	death	inera	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of Hispanic Origin? (§ Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Americ	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ite Modifiel Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Nover Married 1 ☐ Yes 3 ☐		Yes, specify Cuban, Mexican, Puer Yes 2 No Specify:	to Hican, etc.)	Black, White, o	
15-0	"natur	letec	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation kind of work done during most of wo	rking 1	6b. Kind of Business/Inc	dustry
212	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired)		federal	
pu	12 should be filed w h and Mental Hygie f is marked other t traumatic event, II.	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Ma		
ıryla	should be and Mental semarked our marked	Roy Korrell 19a. Informant's Name/Relationship (Type. Print)	10h Mailin	Hilda g Address (Street and Number or Ri	Kepler	City or Town State 7in	Ondel	
, Ma	and 2 s ealth ar n 27 is ner trau		Eric May (Son)	9259	Ridgefield C	ircle, F	rederick,	MD 21701
Baltimore,	Pages 1 and the pages 1 and the pages 1 and the page 1 and the pag		/	matary crom	ition (Name of atory or other place) n cemetery 7/		Oc. Location - City or To	
Balti	permit. Page Department Important: Ii any injury o		21. Signature of uneral Service Licentee	22 D	Name and Address of Facility	- Loson Fun	eral Home	
			23a, Part 1. Enter the disease or complications the caused the death.	Do not ente	r the mode of dying, such as cardia	c or respiratory arres	5t,	Approximate
	Physician		Immediate Cause (Final disease or condition	ere	loral Info	rction	1	Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (as a consequence)	nce of):	0			
	D ##	iner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying	nce of):				
	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conseque	ence of):				
09/89	ificate be executed physician and is the burial-transit	edical	d	nico orij.				
		Med	IF FEMALE:					
Ř	death certifi e attending d for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No ☐ Yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal Pregnant at time of the past 12 months a	feath 3□	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
r O	at the o	hysi	9 Unknown 9 Unknown					
ďs,	w requires that the d s been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting to Left Ventucules T	ing in the und	derlying cause given in Part I.	1	cco use contribute to th	
2	@ # CJ	Completed by	0			24a. Was an	24b. Were autor	sy findings available
ř	: The l	Com				autopsy performe 1 □ Yes 2 1	I prior to con	npletion of cause of
VITAI	siclan certifi irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No		Other	th (Check only one)		
10	ig Phy ter this neral d	n: To	27. Manner of Death 28a. Date of Injury 2	8b. Time of	3 ☐ DOA 4 ☐ Nursing H 28c. Injury at Work?	ome 5 Residen	ce 6 ☐ Other (Specify injury occurred)
UIVISION	tendir leath. Ior: Af the fur	catio	2 Accident investigation	Injury	M 1 □Yes 2 □No			
<u> </u>	al or At s after d il Direct ed in by	Certification:	4 Homicide determined determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	et, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the time, date and place estigation, in my opinion, death occu	e, and due to the cau arred at the time, date	use(s) and manner as st e and place, and due to	ated. the cause(s)
	To the vithin 3	Mec	29b. Signature and title of certifier		29c. License number	290	f. Date signed (Month, D	Day, Year)
			+ H. Chotam MD		D58853		7/10/00	9
K	B 6		30. Name and address of person who completed cause of death (Item 2 HABIB C HOTANI 251 E	3a) (Type, Pr	TIETAM STREE	=T, HA	GERSTOWN	, MD 2174
	Stat Registra	~	31. Date filed (Month, Day, Year) 2. Registrar's Signatur		W			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 8, Ju₁y 2009 8:00 P S. Maynard /Medical Emil 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery National Lutheran Home Rockville 8. Date of Birth (Month, Day, Jan. 3, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)}1916 1 XM 2 □ F Months Days Hours Min. Country) Michigan Director 369-09-5032 93 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Midical Evaminer must be notified at 1 Yes 2 □ No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a 14400 Homecrest Road 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 XYes 2 No 1942− If Yes, Give Year or Dates: 1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🗓 No þ Specify: 3 Widowed 4 □ Divorced 1946 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Purchasing Contract Agent Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley E. Pietrzyk ဂ Agnes Koze 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .07 Marcelle M. Stenbakken/Daughter 8610 Bunnell Drive, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/13/2009 Frederick, Maryland Resthaven Stauffer Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 owntre Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner elovo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Exami to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the Inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a. Was an autopsy performed 2 NO 1 ☐ Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1∐ Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 NO Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

Charles W.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Karesh,

32 Registrar's Signature

ORIGINAL

Damascus, Maryland 20872

26033 Ridge Road

13+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia /Medic Examine Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificat has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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Regis	strar	

	1 - State Registrar					Cer	tificate of	Death	7		Reg. N	lo. 9 1	00	21.	31, 3
	1. Decedent's Name	e (First, Midd	le, Last)							2. Date of De Month		ay	Year	3. Time of	Death
n al	DOROTHY	F.	MAURE	R						JULY	9		09	1:30	A M
er	4a. Facility Name (II	f not institutio	n, give street an	nd number)			4b. City, Town,	or Location	of Death		4	c. County	of Death		
	Brooke	Grove	Nursing	Home				dy Sp	_			Mon	tgom		
	5. Social Security N		6. Sex 1 ☐ M 2	,	(In yrs. last bi		If Under 1 Yea Months Days		Min.	8. Date of Bir (Month, Da	th y, Yea	r)	9. Birthr	place (State ontry)	r Foreign
	172-16-		1 10104 2	SI F	88	Yrs.				Dec.1	3, 3	1920	Pen	nsylva	nia
	Usual Residence of 10a. State	10b. County	,		10c. City, Tow	n or Lo	cation						7	10d. Inside Ci	ty Limits
5	Mđ.		gomery				Spring							1 ☐ Yes	2 No
ect	10e. Street and Nur						10f. Zip Code				10a. C	Citizen of \	What Cou	ntry?	
Funeral Director	1037 Wi		Tano					0860			-		l Sta		
era	11. Marital Status	iidi usii		Decedent Ev	er in U.S.	13. \	Was Decedent of		rigin? (Sp	ecify Yes or No				can Indian,	
뎚	1 Never Marri	ied 2∏ Mar	Arm	ed Forces? Yes 2 No es, Give		1	f Yes, specify Cu	ban, Mexica	an, Puèrto	Rican, etc.)		1	ck, White,		
φ	3 ₩Widowed		If Year	es, Give r or Dates:		1	1□Yes 2⊠N	Specify	y:			Specify	y: Whi	te	
Completed	(0)	15. Deceder	nt's Education	- 44)	16a	. Deced	dent's Usual Occ	pation	-4 -6	f	16b.	Kind of B	usiness/In	ndustry	
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Be (17. Father's Name	(First, Middle	, Last)							e (First, Middle		en Surnan	ne)		
၀	James	Frenc	h					R	uth ——	Miller	<u> </u>				
	19a. Informant's Na			•	19		g Address (Stree						. ,		
			er / Dau	ghter			7 Windru								
	20a. Method of Disp		3 □Removal	from State	20b. Place of cemeter	of Dispo ery, cren	sition (Name of natory or other p	ace)		Date	20c.	Location -	- City or T	own, State	
	4 □ Donation			Tom otato	Parkl	awn	Memoria	l Pk	7/1	3/09	Ro	ckvi	lle,	Maryl	and
	21. Signature of Fu	uneral Service	Licensee			22	Name and Add Muriel	ress of Fac	ility rber	Funera	l Ho	ome			
	mu	rel H	. Ba	rhen			P. O.	Box 5	038,	Laytons	svi		Md.	20882	
	23a. Part1. Enter to shock, or hea	he disease, o art failure. Lis	r complications t only one cause	that caused t e on each line	he death. Do	not ent	er the mode of d	ing, such a	as cardiac	or respiratory a	rrest,			Approximation	ween
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	resulting in death)		Di Di	ue to (or as a	consequence	of):								1/2	P
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ysic	1 ☐ Yes 2 ₹			Unknown	ime or death	5	Other (specify)								
Be Completed by Physician/	Part II. Other signi		ions contributing	g to death but	not resulting	in the u	nderlyjng cause o	iven in Par	t I.	23e. Did	tobacc	o use con	tribute to	the cause of	death?
ğ	Sarcord	ori,	home	nten	non	(25	etrova	scula	an	10	Yes	2 No	3 ☐ Pro	bably 4 🗌	Unknown
etec	400 0 1	1.1.10		-		,				Oda Waa		Loah	More aut	anau findingo	ovelleble
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ပိ										1□ Yes	2		1 ☐ Yes	2 No	
	25. Was case refer examiner? 1 ☐ Yes 2		Hospital:	4571			nt 3 DOA	thor 5		th (Check only		- Ca.			
<u> </u>	27. Manner of Deat		28a.	1 ☐ Inpatien Date of Injury	/ 28b.	Time of			Nursing Ho	ome 5 Res				ity)	
tion	1. Natural 2 ☐ Accident	5 Pendi		(Month, Day	Year)	Injury		orƙ? ⊒Yes 2[□No						
ica	3 ☐ Suicide	6 ☐ Could	not be	Place of injur	y - At home, f	arm, str	eet, factory, offic			28f. Location (Street	and Numi	ber or Rui	ral Route Nur	nber,
erti	4 Homicide	deterr	nined	building, etc.	(Specify)		•		1	City or To	wn, St	ate)			
<u>~</u>	29a. Certifier	1 Certifyi	ng Physician:	To the best of	f my knowledg	je, deat	h occurred at the	time, date	and place,	, and due to the	cause	(s) and m	anner as	stated.	
Medical Certification: To	(Check only one)	2 Medica	I Examiner: On and	the basis of a manner stat	examination a ed.	nd/or in	vestigation, in m	y opinion, d	eath occu	rred at the time	, date	and place	, and due	to the cause(s)
Me	29b. Signature and	title of certifi	er				29c. Lice	nse numbe	r		29d. l	Date signe	ed (Month	, Day, Year)	
	→ Br	when					D	439	58		1	177/	VY		
	30. Name and add	ress of persor	n who completed	d cause of de	ath (Item 23a)	(Type,	Print)	A 1	. 54	Ĉ.	, 0	0-0	12.25	101	
	30. Name and add	eldmo	MWD,	3305	N. Lei	Sur	e word	Blv4	1. 11	ver sfr	1019	עריי	wy	106	
te	31. Date filed (Mor		0000	32/Registra	r's Signature	1	Print)		-5						
ar	J	JL 10	2009	Chron	B.	400	CALL.								

24344

Physic	cian
/Med	lical
Exam	iner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

6 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

sicia: edica		1. Decedent's Name Elisa		R •	Mina					2. Date of De July		^{ay} 2009 ^{ear}	3. Time of Death 8:30p M
nine		4a. Facility Name (II	f not institution	, give street and nu	mber)		4b. City, To	own, or Locat	ion of Death		4	c. County of Deat	h
		11503	Elkin	Street	#3		TAT b	eaton				Monta	omery
ral		5. Social Security N		6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year If Ur	nder 24 Hrs.	8. Date of Bi	rth	0.00	hplace (State or Foreign
or		219-55-	1274	1□M 2🙀 F	55	Yrs.	Months	Days Hou	urs Min.	(Month, D	19	54	^{untry)} Peru
	ŀ	Usual Residence of	Decedent							1/0//			I CI u
	Ì	10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	5	Md	Mont	gomery	,	Wheat	on						1 ☐ Yes 2 🖾 No
	DIFECTOR	10e. Street and Nun					10f. Zip 0	odo.			10a C	Citizen of What Co	untry?
2	5			a++ /	10								unu y .
	ng	11503 E	TKIN	Street #	_			0902				Peru	
	runeral	11. Marital Status		Armed Fo		l.S. 13.	Was Decede If Yes, specif	nt of Hispanio y Cuban, Mex	c Origin? (Sp xican, Puerto	ecify Yes or No Rican, etc.)) -	14. Race - Ame Black, White	
		1 X Never Marri		If Yes, Gi	ve -		1 Yes 2	□No <i>Sp</i> e	cify: Dar	uvian		Specify:	White
1	o o	3 Widowed	4 LI Divorced	Year or D	ates:				161	uvian			
1	Сотрыете	(Spec	15. Decedent ify only highes	's Education t grade completed)		16a. Dece	dent's Usual kind of work	Occupation done during retired)	most of work	ing	16b.	Kind of Business/	Industry
	ם	Elementary/Secon		College (1-4or 5+)	1						II	
	5	12				1	Homema					Own Hom	e
	De	17. Father's Name (First, Middle, I	Last)				18. N	fother's Name	e (First, Middle	, Maide	en Surname)	
	0	Ernest	o Mina	a				J	uana	Miniar	10		
١.		19a. Informant's Na	ame/Relationsh	nip (Type. Print)		19b. Maili	ng Address (Street and No	umber or Rur	ral Route Numb	er, City	or Town, State, 2	Zip Code)
		Jyssell	y Ort:	iz/Daugh	ter	117	16 Ge	orgia	Aven	ue Sil	ve	r Sprin	g,Md20902
	1	20a. Method of Disp	osition		20b.	Place of Dispo cemetery, cre				Date		Location - City or	
				3 Removal from	State		_		7/15	/2000	a .	1 · · · · · · · · · · · · · · · · ·	
	-	4 □ Donation		//	G	ate of							ring,Md
ouce		21. Signature of Fu	neral Service	likensee								SERVIC	
ч	_	1/80	20m	art.								r Sprin	g,Md20910
		23a. Part1. Enter # shock, or hea	ne disease, or rt failure. List	complications that only one cause on e	aused the dea	th. Do not en	ter the mode	of dying, suc	h as cardiac	or respiratory a	arrest,		Approximate Interval Between
an		Immediate Cause (Final		ne me	tacta	cic						Onset and Death
al		resulting in death)											-1
er				C	(or as a consec ervica	l can	cer					ŀ	
	ē	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	nditions, mediate	b Due to	(or as a consec	quence of):							
	Ехапппег	Cause (Disease or	rlying injury										
	×	that initiated events resulting in death) L	_ast	C Due to	(or as a consec	quence of):							
			75									-	
3	an/Inedical			u									
/W.W.		IF FEMALE:		23c. If yes, ou	tcome of pregn	ancv						22d Data of da	ivery
		23b. Was decedent in the past 12	pregnant months?	1 🗆 Live	birth 2 Fet	al death 3						23d. Date of de Month	
1	35	1 ☐ Yes 2 █ 9 ☐ Unknown		9 Unkr	nant at time of nown	dealli 5	Other (spe	CITY)					
1	Completed by Physic	Part II. Other signif		ne contribution to	eath but not re-	culting in the :	inderlying as:	ise given in F	Part I	236 Did	tobacc	Luse contribute +	the cause of death?
1 3	2	raitii. Other signii	icani conditio	ns contributing to d	eath but not les	salang in the c	inderlying car	ase giveri iii r	airi.				
3	100									''	res	2 M No 3 □ P	robably 4 🗌 Unknown
1	b b									24a. Was		24b. Were au	utopsy findings available completion of cause of
	5									perfe	ormed?	death?	2 No
	e l	25. Was case refer	red to medical					26. F	Place of Deat	th (Check only			20110
		examiner? 1 ∐ Yes 2 😾	No	Hospital: 1 🗆	Inpatient 2	BR/Outpatie	nt 3 🗆 DOA	Other: 4	Nursing Ho	ome 5 t Res	idence	6 ☐ Other (Spe	cify)
		27. Manner of Deatl		28a. Date	of Injury oth, Day, Year)	28b. Time o	of 28	c. Injury at Work?		28d. Describe			
	2	1 ➡Natural 2 ☐ Accident	5 Pending investig		tn, vay, rear)	Injury	М	1 ☐ Yes	2 □No				
	2	3 Suicide	6 ☐ Could r	ned 28e. Place	of Injury - At h	iome, farm, st	reet, factory,	office		28f. Location	Street :	and Number or Ri	ıral Route Number,
	=	4 Homicide	determ	build	ing, etc. (Spec	ту)				City or To	wn, Sta	ate)	
3	2	29a. Certifier	1 √ Certifvin	g Physician: To the	best of my kn	owledge dea	th occurred a	t the time da	ite and place	and due to the	e cause	(s) and manner a	s stated.
	Medical Certification: 10	(Check only one)		Examiner: On the b									
2	<u>ĕ</u>	29b. Signature and	title of certifier				290	License numl	ber		29d. Г	Date signed (Mont	h, Day, Year)
				n //	1			-3	551		7	W/W 14	8,009
		1	and ,	11/fer	nella				1		7	77'11	
		30. Name and addr			,								
				ell M.D.	2730) Univ	rersit	y Bly	vd.W	#400 W	hea	aton, Md	20902
State		31. Date filed (Mon		2000	Registrar's Sign	ature	Med.						
stra		JU		LUUJ KEM	from the	c. 147 64	En de service of the						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 30 pm 2009 Donald Wilson Martin 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, July 13 5. Social Security Number 7. Age (In yrs. last birthday) Days 226-52-9687 July | 1942 67 VA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2XXVo PA Franklin Greencastle 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11701 Stull Road 17225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No white Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) owner lawn service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lacy E. Martin Sr. Sally Josephine Bartley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Diane A. Martin wife 11701 Stull Road, Greencastle, PA 17225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 🗷 Removal from State Dale Memorial Park 07/28/2009 Chesterfield, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Grove-Bowersox Funeral Home, Inc. 50 South Broad Street, Waynesboro PA 17268 Jores Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a o'nsequence of): Moderately Squamous Cell Concer disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown pulmonon 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

The law requires that the death certificate be executed

signed by the a d be detached f

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cate has I page 2 s

this certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stelly filled in by the funeral director, p

e Funeral I

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Completed by

Be

Certification: To

Medical

Box 68760,

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Records,

of Vital

Division

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examination at the rollified at

72 hours after

filed within 7 I Hygiene.

is marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event, once.

Baltimore, Maryland 21215-0036

say, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner and physician and s the burial-tran that initiated events resulting in death) Last Physician/Medical attending p IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(prongo

25. Was case referred to medical examiner? 1 Yes 2 1 No

1 hpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 5 Pending investigation 1 LNatural 2 Accident 6 ☐ Could not be 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month. Day, Year)

29b. Signature and title of certifier m, ander

determined

162588

2009

State Registrar

31. Date filed (Month, Day, Year)

JUL 29 2009

	1	For State Registrar	State of N	Maryland	•	artment of tificate o		and Mental	Hygiene Reg. No	UUD	24346		
Physicia		Decedent's Name (First, Middle Tam	e, Last) es Oliver	Matt	hews			2. Date of Month July		y 2009	3. Time of Death 12:55 A M		
/Medic / Examine		4a. Facility Name (If not institution			.IICW D	4b. City, Town	, or Location of			. County of Dea	th		
		18936 Middle		Age (In yrs. I	n at hintholass	If Under 1 Yes	Parkt		d Righ	Balti			
Funeral Director		5. Social Security Number 215-34-6032	182 M 2□F	72	Yrs.	Months Day		Min. (Monti	of Birth n, Day, Year, 8, 19	37 Ma	thplace (State or Foreign ountry) ryland		
pu ×	- 1	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits		
Maryla			timore			Pa	arktor	1			1 ☐ Yes 2₺ No		
ith the	Director	10e. Street and Number	_			10f. Zip Code				itizen of What Co	ountry?		
eeth w	<u>e</u>	18936 Midd	12 Was Deceder	nt Ever in U.	S. 13.	Was Decedent of	21120			J.S.A.	erican Indian,		
S	6	1 Never Married 2 Mar 3 Widowed 4 Divorced	ined Armed Force	s? ANo	-	f Yes, specify C		gin? (Specify Yes on, Puerto Rican, etc	.)	Black, White, etc. Specify: White			
21215-0036 ad within 72 hours eff glene. er then "naturel", or t, the Medical Exern	Completed		t's Education st grade completed)		16a. Deced (Give	tent's Usual Oct kind of work dor DO NOT use ret	cupation ne during mos	18b. F	Kind of Business	/Industry			
212 d withir	dmo	Elementary/Secondary (0-12)	College (1-40	or 5+)		strial			Ma	nufact	curing		
be filed that Hyg od othe	Be	17. Father's Name (First, Middle, Clarence C.		12++h	OWE			er's Name (First, M ry Elle:					
Maryland od 2 should be file lith and Mental Hy 27 is marked oth	၉	19a. Informant's Name/Relations		ia L LIII		ng Address (Stre		er or Rural Route N			Zip Code)		
ore, Ma		Jessie J. Ma						n Rd., F					
Baltimore, bermit. Pages 1 a Depertment of Hee Important: if them any injury or othe pages.		20a. Method of Disposition 1 St Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5			seburg	sition (Name of matory or other p Cemete	ry	July 25 2009	W hi	ocation-City or Lte Hal	1, MD		
Balt permit. Depend Import		21. Signature of Funeral Service	Licensee Meur	me.				y J. J. H , New Fr			ortuary Inc. 349		
8760, zate be executed Whosician end in buriel-transit	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death 2 YEANS 2.5 YRS		
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or At fler of lines in by	Certification;		gation not be 28e. Place of		ome, farm, str		☐Yes 2☐	28f. Locat	ion (Street a or Town, Stat	nd Number or R le)	tural Route Number,		
Divi	edical C		ng Physician. To the be Examiner: On the basis and manner	of examinat									
To th within To th comp	Me	29b. Signature and title of certific	Stopler	- Mm	0	29c. Lice	onse number	155	29d. Da	ate signed) (Mon	th, Day, Year)		
		30. Name and address of person	who completed cause of	MX	2 . /	Print) 1692-1	you	KRD	MON	KTON	MD 211/1		
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar	State of	Maryland	d / Depa <i>Cer</i>	artment of F <i>rtificate of I</i>	lealth and N Death	/lental Hy	giene Reg. No.	09	24347			
		Decedent's Name (First, Middle)				tinodio or i		2. Date of De	ath		3. Time of Death			
Physicia /Medic		Katie VanHook	Nagy					July	B, 2009	Year	0100 M			
Examin		4a. Facility Name (If not institution					Location of Death		4c. Count					
		Anne Arundel M				Annapo If Under 1 Year			Anne					
Funeral Director		5. Social Security Number 245–30–2684	6. Sex 1 □ M 2√2 F	Age (In yrs. Ia 84	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8/23/1	y, <i>Year)</i> 924	9. Birth	place (State or Foreign ntry) NC			
pu.		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation				Τ.	10d. Inside City Limits			
Maryia -f sho	tor		rundel	Toc. Oity,		apolis					1 □ Yes 🛣 No			
with the Sa or 28a	Funeral Director	10e. Street and Number 2650 Greenbria	ır Lane			10f. Zip Code	21401		10g. Citizen of What Country? USA					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Madical Evaruate any injury or other traumatic event, it is Madical Evaruate any injury or other traumatic event, it is Madical Evaruate and instituted at once.	by	11. Marital Status 1 Never Married 2XMarr 3 Widowed 4 Divorced	ied 12. Was Decede Armed Force 1 _ Yes 2 If Yes, Give Year or Date	es? ⊠No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2X No Specify: Black, White, etc. Specify: White									
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Ald be Aental rked o	To B	Samuel VanHook	·				Ve1ma	Keen						
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Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_a/	h line. Myocas as alconseque	-lin	inf	velia				Interval Between Onset and Death			
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or Attending Physician: The law requires that the death certificate be executed iter death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ld. Date of delivery Month Day Year										
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ne faw require s has been si ge 2 should b	Completed							24a. Was auto	an 24b.	Were auto	opsy findings available ompletion of cause of			
sician: The certificate h rector, page		25. Was case referred to medical			· -		OC Place of Deat	1 □Yes	2 No	1 ☐ Yes	2 No			
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of	Injury - At hon , etc. (Specify)	ne, farm, stro	eet, factory, office		28f. Location (City or To		ber or Run	al Route Number,			
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To the within To the Complete	Me	29b. Signature and title of certifie				29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)			
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(2:-	ľ	30. Name and address of person		Y D		Print)	Sut, 40		/					
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Registra		JUL 10	2009 Centre	istrar's Signatu	pa	Ke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Dona1d Patrick 01iver 2009 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner LVISTA Year If Under 24 Hrs 8. Date of Birth (Month, Day, June 7, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday If Under **Funeral** 1√2 M 2□ F Months Days Hours Min 577-46-4389 76 1933 Director Maryland Usual Residence of Decedent 10a. State 10d Inside City Limits 10c. City. Town or Location ed other than "natural", or Items 23a or 28a-f show event, the Medical Exercitur roust by notified at 1 ☐ Yes 2 No Director MD Charles Cobb Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12129 Neal Sound Drive 20625 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐**Y**es 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 Never Married 2 Married 1∐Yes 2∐XNo If Yes, Give Year or Dates þ Specify White Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry الله Albert who. Thygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waterman Commercial and Mental Hygi permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Obie Oliver Mable Johnson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Bowling/Daughter 12129 Neal Sound Dr. Cobb Island, MD 20625 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Holy Ghost Cemetery 7/17/09 4 ☐ Donation 5 ☐ Other (Specify) Issue, Maryland 21. Signature of Funeral Service Lice AREHART-ECHOLS FUNERAL HOME, P.A. M01458 211 St. Mary's Ave. La Plata, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or At ending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal deat

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📶 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 □ Yes 2 **Z** No 25. Was case referred to medical a examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ည 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: A fter 5 Pending investigation 1 🗷 Natural 1 ☐ Yes 2 ☐ No filled in by he f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifie 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifie Date signed (Month, Dav. Year)

Db b

31. Date filed (Month, Day,

JUL 1 5 2009

Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 118 LA GRANGE Aggistrar's Signature Bereva B. Janes

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month EDNA VIOLIA PITTINGER 8:30 p JULY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth June 2, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Days 215-26-2062 Months Min. Maryland 84 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Marical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Frederick M∏Yes 2 ☐ No Thurmont 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 12 Lombard Street 21788 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 □Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify: Sq. Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Claire Frock 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William A. Smith Edith L. Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Stambaugh / Daughter 411 East Main Street, Thurmont, Maryland 21788 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Garden's 7/17/09 Frederick, Maryland 21. Signature of Puperal Service 22 Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that daused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) about ramy /Medical ue to (or as a consequenc of): Examiner Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician the burial Box 68760, Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. been signed by the should be detached 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s 24a. Was an autopsy performed certificate 1 □Yes 2 No 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → 16 2 ER/Outpatient 3 DOA this 1_Inpatient Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D60417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) shall Frederici Thomas Tohnsan DV 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2009 Registrar

			For State	State of Ma	aryland / Depa <i>Ce</i>	artment of F <i>rtificate of I</i>			giene Reg. No.2	09	24350			
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	pu »		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ncation				11	0d. Inside City Limits			
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Marical Examiner runst be retified at once.		21. Signature of Funeral Service Licensee MO1521 MO1521 MO1521 MO1521 MO1521 MO1521 MO1521														
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)	2☐ Medical	Examiner:	On the basis on the basis on the basis of th	of examina	tion and	or investi	gation, in my	ime, date and place opinion, death occu	rred at the time,	date and	d place, and du	e to the cause(s))	
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W.		Doo26064 07-22-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) / 10583-THEODORE GREEN BLVD														
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Stat	te	31. Date filed (Mon							-	11-10-1		1	V -			
Registra	ar	J	UL 23	ZUUS	Caron	N	7. 1	Tare	~							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) J_{u}^{Month} **Physician** 7, 2009 2:30A. M Josephine Lorraine Purdy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min. Hours 83 Yrs 235-38-6756 April 16,1926 West Virginia Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 X XO Mitchellville Prince George's Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 items 23a U.S.A. 20716 Funeral 18104 Central Avenue death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No 14. Race - American Indian, Black, White, etc. White permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event 1 □ Never Married 2 □ Married 1 □Yes 2 □No Specify: Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify ò 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry
Prince George's County 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public School System School Bus Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Retta K. Ramsborg Harvey E. Allman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1424 Bidwell Lane, Huntingtown, MD Leah Townsend/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1∰Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 7/13/2009 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Feneral Service Lice 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardination, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Examine the death certificate be executed attending physician and for use as the burial-transit Due to (or as a co quence of Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Lectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29d. Date signed (Month, Dav. Year) 29b. Signature 29c. License number 1637 s of person who completed cause of death Name and add

DHMH 17 Rev 1/2001

State Registrar

	1	For State Registrar	1 1003				-		t of H	ealth a		ental Hy	giene Reg. No.	200	0 21	. 2 5 2
	-	1. Decedent's Name (F	irst, Middle,	Last)								2. Date of De		Voor		of Death
Physician	ı	HARRY	LLOYD	REICHA	RD							Month JULY	Day	2009	7:3	1 P M
/Medical Examiner	4	4a. Facility Name (If no	t institution,	give street and n	umber)			4b. City,	Town, or	Location of	of Death		4c. C	ounty of Dea	ath	
Laminer	ı	FREDERIC	K MEMO	RTAT. HOS	SPTT	ΊΑΤ		FF	EDER	ICK				FREDEF	RICK	
Funeral Director		5. Social Security Num 195–26–5	139	5. Sex 1 ⊠ M 2 □ F	7. Age		a <i>st birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month, Da 8/30	1937	9. Bi	rthplace (Stat count PA	e or Foreign
pu 🔏	-	Usual Residence of De 10a. State 10	cedent b. County			10c City	, Town or Lo	cation							10d. Inside	City Limits
be filed within 72 hours after death with the Maryland utal Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Be Completed by Funeral Director		MD		erick		100.019		eder	ick							es 2X No
or 28	Ī	10e. Street and Number	r					10f. Zip					10g. Citize	en of What C	ountry?	
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ems		11. Marital Status		12. Was De Armed I	orces?		3. 13.	Was Dece	dent of Hi	ispanic Ori n, Mexicar	igin? (Spe	ecify Yes or No Rican, etc.))- 14	I. Race - Am Black, Whi	erican Indian, te. etc.	
urs after death with the Man al", or Items 23a or 28a-f sh cominer must be notified by Funeral Director		1 ☐ Never Married 3 ☐ Widowed 4 ☐		If Yes, (Year or	: 2□N Give	√195 195	6-	1 □Yes		Specify:				Specify: W		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be inclifted at once. To Be Completed by Funeral Director		19a. Informant's Name Lois Rei)		770	5 Ri	dge	Rd.,		ederic	ck, I	1D 21	701	
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Physician /Medical Examiner		ca, Part 1. Enter the shock, I heart fill immedia 6 Cause (Fir disease or condition resulting in death)	al	a	U.	I the death ne. PCC a consequ	61	ter the model Bl hase	de of dyin	g, such as	cardiac o	or respiratory a	arrest,		Approxin Interval I Onset an	nate Between nd Death
eath certificate be executed attending physician and for use as the burial-transit claran/Medical Examiner		Sequentially list condit if any, leading to finne cause. Enter Underlyi Cause (Disease or inji that initiated events resulting in death) Las	ing 4	c		a consequ		0								V
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requires that the dependence of the detached the detached by the lefted by Physic		Part II. Other significa	int condition	s contributing to	death b	ut not resu	ilting in the c	anderlying of	cause give	en in Part I	l. 		tobacco us		to the cause	
sician: The law requir certificate has been s rector, age 2 should		Ser	ere A	ci do si	2							24a. Was auto perf		24b. Were a	autopsy findin o completion (gs available of cause of
ficate ar. T		OF Man ann votaved	to madical							00 51		1 ☐ Yes	2 2 100	1 □ Y€	s 2 No	
sician certif rector		25. Was case referred examiner? 1 ☐ Yes 2 ☑ ₩	to medical	Hospital:		0.00	50 (O. d 1)		Oth	or:	_	(Check only			***	
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, age 2. Medical Certification: To Be Compl		2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investiga 6 □ Could no determin	ot be 28e. Pla	ce of Inj	ury - At ho c. <i>(Specif</i>)	me, farm, st	mreet, factor		Yes 2□		28f. Location City or To	(Street and wn, State)	Number or I	Rural Route N	lumber,
the Hospital thin 24 hours a the Funeral I ompletely filled		29a. Certifier 11 (Check only one)	KCertifying ☐ Medical E	Physician: To take	he best basis o	of examinat	wledge, dea	th occurred	at the tin	me, date a	nd place, ath occurr	and due to the	e cause(s) , date and	and manner place, and di	as stated. ue to the caus	se(s)
thin 2 the mple	-	29b. Signature and title	e of certifier	and m	armer su	aleu.		29	c. Licens	e number		T	29d. Date	signed (Moi	nth, Day, Yea	r)
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la+1		30. Name and address		- (Print)		- 3		ck, MI	217	01		
State Registrar		31. Date filed (Month,	Day, Year) 152		~ -	ar's Signat		New .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2000 21:43 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Specialty Hospital City Baltimore Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🕱 F 225-18-7928 Director 87 08-01-1921 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or items 28a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 1 Yes 2 No Directo Md. Dorchester Cambridge 10e. Street and Number 10g. Citizen of What Country? 642 Washington St., Apt. #B 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 □ Divorced ear or Dates: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Yonkers RaceTrack Horse Trainer 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith ပ Harmon John Fosque 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Rogers / Son 642 Washington St., Cambridge, Md. 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cambridge, Md. Bether Church Cem: 06-11-09 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bennie Smith FuneralHome 524 Race Street, Cambridge, Md. 23a. Pal 1. First the disease, or complications fill occuse of shock, or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy performed Yes 2 No 1 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

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32. Registrar's Signature

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0450M 2009 Naomi Yvonne Richman JUIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Hospita Vlemorial Easton If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 4/29/1930 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days 1 □ M 2 😾 F Months Hours 218-26-2403 79 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 □ No Director Maryland Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 701 Gables at Caroline 21629 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Tes 2 X If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🎇 No Specify ð Specify: 3 ☐ Widowed 4 🎇 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) es 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12th Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Collins Norman Hinton P Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trat 27 Victory Ct., Jacksonville, FL 32250 Kendall White/ Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 7/9/09 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 21. Signature of Funeral Service Lice 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chyonic **Physician** 05 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1XIYes 2 No 3 Probably 4 Unknown 24a. Was en 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed this certificate 1 ☐ Yes 2/2 No 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifie

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

norte 31. Date filed (Month, Year) 09

AUC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regintrar's Signature

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			For State	State of Ma	rylan	-	artment			and M	lental H		000	3	21.35	5		
			Registrar 1. Decedent's Name (First, Middle, Las	t)		Cer	lincale	OIL	Jeani		2. Date of D	Reg. Neg	LUU.		3. Time of Deatl	<u> </u>		
В	Physici		Margaret Redmo	•							Month	Day 8						
	/Medic		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	of Death	June		County of E		10:12 F	-		
			Calvert Memorial	Hospital			Pr	ince	Fred	eric	.k	C	alvert					
	Funeral		Social Security Number	7. Age	(In yrs. I	ast birthday)	If Under Months		If Under		8. Date of B		9. Birthplace (State or Fo					
	Director		5/8-20-0735	□M 2 1 2 F {	38	Yrs.	WOTHIS	Days	Tiours	WIIT I.		3/192						
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation								d. Inside City Lim	ito		
	f sho	5	Maryland Anne Aru	nde1		Church								10	1 □ Yes 2√			
	the 28a-	Director	10e. Street and Number				10f. Zip	Code				10g Citi	10g. Citizen of What Country?					
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Z	e filed within 72 al Hygiene. other than "nai vent, the Medics	ပိ	12 Homemaker 17. Father's Name (<i>First, Middle, Last</i>) 18. Mother's Name (<i>First, Middle, Last</i>)															
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pairimor	+ + # =		21. Signature of Funeral Service Licens						- 1			1						
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	1817/34		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused t	the death								-		Approximate			
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	/Medical		resulting in death)	a. Encl Due to (or as a	consequ	ence of):			di.					+		_		
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	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ence of):												
	ecute and -trans	Examine	that initiated events resulting in death) Last	D														
0000	cate be executed oblysician and the burial-transit	Ê		Due to (or as a	consequ	ence or):												
0	physicate the	dical		d										+				
X	the death certifica the attending ph ched for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome p	f pregnar	acv.										_		
מ	atter for u	cian	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal	death 3□	Ectopic pre					2	3d. Date of Month		ay Year			
į	the d y the iched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	inic or de	au	Other (spe	city)										
	that ned b deta		Part II. Other significant conditions co-	ntributing to death but	not resul	lting in the un	derlying car	use giver	n in Part I.		23e. Did	tobacco u	se contribute	to the	cause of death?			
25	quire;	d by	Dementic								1 🗆	Yes 2]No 3□	Probal	oly 4 🗷 nknov	vn		
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	The Ister than the harmonic age 2	E O									auto perf	psy ormed2/	prior	to comp	pletion of cause o	f		
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2	arth. or: Af	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(World), Day	rear)	Injury	М		es 2 □ N	lo								
2	or Attending Physician: The law requires that the death cer that death. Director: After this certificate has been signed by the attendin in by the funeral director, page 2 should be detached for use.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury	y - At hon	ne, farm, stre	et, factory,	office		2	8f. Location	(Street and	Number or	Rural F	Route Number,			
2	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. The Tro the Funcaral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director, page 2 should be detached for use as a second to the funeral director.	Ce																
	Hosp 4 hou Funel	ca	Check only 2 Medical Exami	sician: To the best of ner: On the basis of e	my know	ledge, death	occurred a	t the time	e, date and	place, a	nd due to the	cause(s)	and manner	as stat	ed.			
	the hin 2 the mplet	Medical	0.10)	and manner state	ed.						- I							
,	₽ ₹ ₽ ፬		29b. Signature and title of certifier	a. Sin	~ 1.	~		License		6.3			signed (Mo					
1	.0	-	. –				-			دد			- 7	20	204			
2	29		30. Name and address of person who co	empleted cause of dea	ath (Item a	23a) (Type, P	rint) Ce	VA	N.C		URB	N 17	الله					
	Stat	e_					. ७ स स		vea	ue.	mi	2	2075					
	Registra		31. Date filed (Month Day Year) 2	UU9 Dener	~	A. A	arke	7										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #20state of Maryland / Department of Health and Mental Hygiene - State AMENDED 07/14/07 per FCHD retificate of Death KB and #20b&c Per FH G896 10/09/09/19 2 Date of Death 3. Time of Death Day **Physician** LUCIA 1:10 A M S. SCOTT 27, 2009 JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5737 Meyer Ave. New Market Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F Months 78 Director 236-48-7892 June 16,1931 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Frederick permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a any Ilury or other traumatic event, Its Profect Exercises must be sufficient. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6893 Arbor Court 21703 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify: 2 Specify: 3 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marco Spinelli Carelli ္ရ Pasqua 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belinda Gruber /daughter 5737 Meyer Ave./New Market, Maryland 21774 20c. Location - City or Town, State
Arlington
Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct.06,2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Arlington Nat. Cemetery 22. Name and Address of Facility

Stauffer Fu

1621 Opossumtown Pike, Freder

23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

23. Name and Address of Facility

Stauffer Fu

1621 Opossumtown Pike, Freder

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Stauffer F Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21703 Approximate Interval Between Onset and Death **Physician** MONTHS /Medical Examiner Fihn Ildian MESMITHS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tra Due to (or as a consequence of): Box 68760. attending physician for une as the buria law requires that the death ertificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? has The certificate 1 ☐Yes 2 ☐No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Naughters 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of this Date of Injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending | 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29b. Signature as of certifier 29d. Date signed (Month, Day, Year) 00062223 4 30. Same and address of person who completed cause of death (Item 23a) (Type, Print) 196 TJDLIVE, PREDELICE, MD KB PLAYE ON BOLARUM HD 31. Date filed (Month, 32. Redistrar's Signature Day, Year) State 0 Registrar

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 10, 2009 **Physician** 5:21 AMNELSON WALLACE SAXON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours 1√√M 2□ F 204-28-3933 70 Dec 28, 1938 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examination to refitted at any injury or other traumatic event, it is Medical Examinations. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2€ No Director Adamstown Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 1864 Pleasant View Road 21710 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married black Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 10 Elementary/Secondary (0-12) College (1-4or 5+) construction Construction laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Mozelle Nimmons Robert Saxon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1864 Pleasant View Road, Adamstown, Maryland 21710 Shirley Saxon - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Frederick, Maryland Stauffer Crematory 7/14/2009 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Pike, Frederick, Maryland 1621 Opossumtown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760. cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐Yes 2 ☐ No 2 X No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 ☑ Natural 5 Pending 1 ☐Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 D Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07,10,09 MDD66218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

KB

State Registrar

31. Date filed (Month, Day, Year)



ORIGINAL

Haroon Akhtar, MD

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death _Month **Physician** ESTER 18'14 Jul 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 **⊠**M 2 □ F 214-68-6178 **Director** MARYLAND 9-30-1956 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Director MARYANG (10e. Street and Number SALISBURG Wicomico 10g. Citizen of What Country? 10f. Zin-Code 21801 U 5A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Black ģ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NONE Elementary/Secondary (0-12) College (1-4 or 5+) LABORER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Church SAMUEL MAE Simpson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAE Simpson - Nother 569 VILLAGE Salisbury, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)

Shiebury Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-18-09 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FUNERAL Stewart Home 821 Salis, Md 23a. Part 1. Enter thy disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** intraci disease or condition resulting in death) /Medical Examiner C nexclos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4 Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 5 Residence 6 Other (Specify) this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: I Director: After to in by the funer 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 🗌 Yes 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of confier 29c. License number 0 ma Phi 167406 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rober toesch mo , PhD 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Indeli Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year 2009 **Physician** Tocks -- Probert Robert Socks 1542 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore City University of Mostard Medical Center Bultimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 15, 1943 9. Birthplace (State or Foreign **Funeral** 1.KM 2□ F Months Days Hours Min. 216-38-0854 Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan cartment of Health and Mental Hygiene.

ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Mexical Examination with the Mexical Examination. 10d. Inside City Limits Director Maryland Washington County 1 Yes 2 ☐ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 S. Cannon Ave. Apt 2 21740 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roofer Roofing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Richard Socks Anna Elizabeth King Socks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Socks-wife 30 Cannon Ave. Apt 2 Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important; If it any Injury or once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory | 7-11-2009 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nulti-organ system failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Reportision Injus / Rhabdono Dlysis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Acute critical Ischemia of Right Upper Extremity burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day signed by the a 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Vescolor page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed CAD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 □Yes 2**9**No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural
2 Accident hours after death 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BARAON, JUSTIN 1922289438

Registrar

State

T3 altomary

22

32 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Justin Borock

31. Date filed (Month Pay

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year July 5 2009 Hattie May Thompson 3:18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🂢 F **Director** 218-30-7945 74 23, 1934 Maryland Nov. Usual Residence of Decedent death with the Maryland f show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, Inc. W. clost Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland | Montgomery Damascus 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 26825 Dix Street 20872 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify δ Specify: 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Receptionist Senior Citizens Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Herbert Mobley Esther Mary Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Kenneth Thompson, husband 26825 Dix Street, Damascus, Maryland 20872 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or or 1 XBurial 2 Cremation 3 Removal from State Resthaven Memorial Gardens Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityMolesworth-Williams Funeral Home Signature of Funeral Service Licenses 26401 Ridge Road, Damascus, Maryland 20872 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cruse (Final disease of ondition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissass or injury that initiated events Due to (or as a consequence of) Examine certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760 physiciar Physician/Medical the as attending IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I the detached 9 ☐ Unknown 9 Unknown signed by the The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, CARCINOMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen : CWSTRIDIUM DIFFICILE COLITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate of Vital 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? Division the Hospital or Attending Iniury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 10 29c. License number 29d. Date signed (Month, Day, Year) Hubbr Madhavi D62562 July 7. 2009 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KB Madhavi Hubbly, MD, 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 07 JUL Backe Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician EULA** Mae TATE July 2009 9:29 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 17, 1 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2X F Michigan 60 1948 Director 376-50-2396 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □ Yes 2X No ir than "natural", or items 23a or 28a-f shipe Medical Examiner must be notified Director VΑ Fairfax Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14725 Calvary Place 20121 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify. Specify: 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Lobbyist Labor Union other traumatic event, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental H Leslie Booker 0 Genia Webster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 of Health a Ronnie G. Tate-Husband 14725 Calvary Place, Centreville, VA Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) = 5 Highland Cemetery Jul 23 2009 Ypsilanti, Michigan 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8914 Quarry Road CC0208 Ames Ames Funeral Home, Inc., Manassas, VA 20110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG YETASTATIC **Physician** 121105 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physician and use as the burial-tran Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, GASMOINTESTINAL BLEEDING 1∏Yes 2 🗌 No 3 Probably 4 Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an director, page 2 autopsy performed? Yes 2 this certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2010 1 ☐ Yes Medical Certification: To After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 11 User frying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 023308 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6420 ROCKLEDGE OR BENTESOA, MD 20817 VICTOR M. PRIEGO, 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 15 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., gegartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 1305 FM 2000 lowns Carol /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of Maryland Medical Center
5. Social Security Number 6. Sex 17. April 10 years 100 to 150. BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral 1□ M 2 1 F 213-38-7768 Months Days Hours MO VOV 4 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If then 27 is marked other than "natural" or the market of the than "natural" or the market of the than "natural" or the market of t 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location FREDERICK FREDERICK 1 ØYes 2 ☐ No MA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA SAINTS 57. 21701 11 EAST ALL Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2/1 No Specify. Specify: BLACK 2 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) NURSING Home Elementary/Secondary (0-12) College (1-4or 5+) HOUSE KEEPING FACILIT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GRAFTON E. JACKSON ANNIE NICKENS ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANDREV. JACKSON ILEAST ALL SAINTS ST FREDERICK MO 21701 (SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ESTHAVEN MEN. GAR, July 25, 09 FREDERICK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CARY L. ROLLINS 21. Signature of Funeral Service Licenses xuu X. lollis 21701 110 WEST SOUTH ST FREDERICK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Multi – drug resistant infection call more date. Approximate Interval Between Onset and Death drug resistant infection causing Immediate Cause (Final **Physician** tre Shoc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia and bacteremia Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-trans and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) □Yes 2 No signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **N**0 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation 1 □Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

O. Box 68760,

Division of Vital Records, P.

DHMH 17 Rev 1/2001

Registrar

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22 South Greene

Registrar's Signature

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BALTHROPFE, MD

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SAMPSON

31. Date filed (Month, Day, Year)

JUL 2 9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

July 15 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Natalie Tsonev 2009 /Medical County of Death Town, or Location of Death acility Name (If not institution, give street and number, 4c. 4b. City, **Examiner** THAR IVISTA MEDICAL ENTER Hrs. 8. Date of Birth Min. (Month, Day, Year) February 12,1921 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Ukraine Months Days Hours 1 □ M 2√2 F 067-28-9783 88 **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Medical Examinet in 1915 to 1917 of once. 1 □Yes 2 □No Director MD Charles Cobb Island 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15481 Potomac River Drive 20625 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify SONEV, NATALIE Specify: 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Language Editor Federal Govt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gregory Bondar Olga Fill ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Bradshaw/Grandson P.O. Box 41 Cobb Island, MD 20625 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Russian Orthodox Convent7/17/09 Spring Valley, NY 4 Donation 5 Dother (Specify) 21. Signature of Funeral Servi 22 AREHART-ECHOUS FUNERAL HOME, P.A. M01458 St. Mary's Ave. La Plata, MD To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (Examiner enmon Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit Exami 0 29 and Due to (or as a consequence of): attending physician for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to Jeath but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 Unknown icate has been si page 2 should b 1 Tyes Completed ∕24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Medica

1 Center 7C Postoffice Rd.

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

enna

Chon

JUL 1 5 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Orville Nathaniel Thomas 2009 July 12:35P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 106 Boyce Mill Road Greensboro Caroline 8. Date of Birth (Month, Day, June 2 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours Min. 60 June 1949 218-50-2126 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 Boyce Mill Road 21639 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mechanic farm equipment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0 Jacob Mitchell Thomas, Sr. Gertrude M. Newman Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina Thomas/ 106 Boyce Mill Road; Greensboro, MD 21639 wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State Greensboro Cemetery | July 15 2009 4 ☐ Donation 5 ☐ Other (Specify) Greensboro, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cong est disease or condition resulting in death) Due to (or as a conse jui nce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 - Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown

Physician /Medical Examine

Funeral

Director

28a-f show

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Health and Mental Hygir em 27 is marked other

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr.

should be

72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

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Physician/Medical \$

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Completed Be Certification: To

or Attending Physician; The law requires that the death certificate be executed the signed by to has page certificate director, After this of hours after death.

uneral Director: A

sly filled in by the fu To the Hospital within 24 hours a completely

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b, Time of 28d. Describe how injury occurred 1/2 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7534 0 004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Zaki 920 Market Street, Denton Maryland 21629 31. Date filed (Month, Day, Year) 1 5 2009

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Registrar DHMH 17 Rev 1/2001

State

			For State Registrar	State of Ma		artment of F <i>rtificate of</i> :	lealth and Me <i>Death</i>		iene _{eg. No.} 2 () () (24366
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	Physicia /Medic	_	NILA NYUNT	WIN				JULY	10 2009	
	Examin	er	4a. Facility Name (If not institution, give Shady Grove Adve		nital	4b. City, Town, o	r Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday,	1		8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
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	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	Md. Montgo	mery	Rockvi	llle				1 ☐Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code	20853	11	0g. Citizen of What C	
	s 23a		13700 Loree Lane	12. Was Decedent E	vor in II S 12	Was Decadent of L		oify Vos or No-	United 14. Race - Am	
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show in Madical Examinar must bu nuiting at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 1 No If Yes, Give Year or Dates:	o 13.	1 ☐ Yes 2 ☒ No	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	lican, etc.)	Black, Whi	
15-0	"natu	letec	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece (Give	edent's Usual Occup	oation during most of working d)	g	16b. Kind of Business	/Industry
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pu		Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			
ylaı	should be fand Mental marked o umatic eve	70	U Nyunt Pe				Daw Kh			
, Maryland 21215-0036	alth a		19a. Informant's Name/Relationship (Ty U Hla Win / Husb			,	Lane, Roc		, City or Town, State, Md. 2085	
altimore,	Pages 1 and nent of Healt int: If item 2: iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other plac	ce) Da		20c. Location - City o	
tim			4 ☐ Donation 5 ☐ Other (Specify)			litan Cre		/09	Alexandria	ı, Virginia
Bal	permit. Departi Importa any inji		21. Signature of Funeral Service Licens	//	00470		. Barber F		Home ille, Md.	20882
			23a. Pary 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused t ne cause on each line	the death. Do not er e.	ter the mode of dyi	ng, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
The last	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	STATIC BRI	EAST CANCI	ER			
Total Control	Examiner			Due to (or as a	consequence of):					
	P .±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a	consequence of):					
	ecute and trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	C	consequence of):					
68760,	ficate be executed g physician and s the burial-transit	alE		Due to (or as a	consequence or).					
	÷ 50	ledical		G						
O. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of do Month	elivery Day Year
ď.	res that signed b be deta	by Pr	Part II. Other significant conditions co	ntributing to death but	t not resulting in the o	underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ord	v require been siç should b							1 □ Y€	es 2 ☑No 3 ☐ F	Probably 4 Unknown
Division of Vital Records,	. The cate h page	Completed							y prior to ned? death? 2 ☑No 1 ☐ Ye	utopsy findings available completion of cause of
ΖÏ	s certil	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	dospital:	nt 2 ER/Outpatie	ont 3 🗆 DOA Oth	26. Place of Death	, , , , , , , , , , , , , , , , , , , ,	e) ence 6 □Other (Sp	ocife)
J of	ing Phy h. After this funeral c	n: To	27, Manner of Death	28a. Date of Injury (Month, Day)	y 28b. Time				ow injury occurred	в спу)
sion	Attending at death. ector: After by the funer	catic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 □	Yes 2 □No			
Divi	al or Attends after death	Certification:	4 Homicide determined	28e. Place of Injuition building, etc.	ry - At home, farm, si (Specify)	reet, factory, office	2	8f. Location <i>(St</i> City or Towr	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending Physician, within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (examination and/or i				ause(s) and manner ate and place, and du	
	To th within To th comp	Me	29b. Signature and title of certifier	1		29c. Licens		2	9d. Date signed (Mor	
	5		▶ B.S. Ma	dar.	MO	D O	067512		July 10,	2009
	KB 3		30. Name and address of person who comes Madan Bangalore,				r Drive, R	ockvill	e, Md. 20	0850
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 3 2009	32. Registra	r's Signature	who				

			1 - For State of Maryland / Department / Department	artment of Health and N rtificate of Death	Aental Hygier Reg. I	711119 74307
		<i>18</i>	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
3	Physicia /Medic	_	John Willard Warfield		July 8,	2009 Year 5:00A M
1	Examin	10.50	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		3	2879 Florence Road	Woodbine		Howard
7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
40	Director		Usual Residence of Decedent		Feb. 14,	1918 Maryland
	and w		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryl f sho ied a	호	Maryland Howard Woodbi	ino.		1 □ Yes 2 😿 No
	28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3a or		2879 Florence Road	21797		U.S.A.
	death	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerle	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
9	after or ite mlne		1 □ Never Married 2 □ X Married 1 □ Yes 2 X No	1 ☐ Yes 21 ☐ No Specify:	or today, oto.,	Specify: White
8	72 hours after death with the Maryland natural", or items 23a or 23a-f show dical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	**		
7	"natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	. Kind of Business/Industry
12	within ene. than "	ם	Elementary/Secondary (0-12) College (1-4or 5+)	ning & Design Eng	1	Martin Aircraft
d 2	filed Hygid ther ent, tl		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	den Surname)
Maryland 21215-0036	d be ental ked o c eve	To Be	Robert G. Warfield	Ruth	Virginia	Molesworth
7	2 should be and Mental is marked c raumatic ev	-	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Ru		
	1 and 2 Health a em 27 is other trai		D. Madeline Warfield - Wife 287	9 Florence Road,	Woodbine,	Marvland 21797
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. Place of Dispo			Location - City or Town, State
Ĕ	Pages nent of I ant: If ite ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Poplar S	prings Cemetery 7	/11/09 Mc	ount Airy, Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signalure of uneral Service Licensee	2. Name and Address of Facility lolesworth—William	cPΔ F ₁	ineral Home
_	90 F # 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	6401 Ridge Road,	Damascus,	Maryland 20872
т.			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
4	Physician			HEART DISEA	52	9 EARS
6	/Medical Examiner		Due to (or as a consequence of):			,
6.	- Xuiiiii	<u>.</u>	Sequentially list conditions, b.			
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			
	al-trai	xar	that initiated events resulting in death) Last C			
8760,	cate be executed oblysician and the burial-transit	cal	d			
9	ificate g phys as the	edic				
Вох	the death certific y the attending p ched for use as f	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3	⊒Ectopic pregnancy		23d. Date of delivery
	deat e atte	icia		Other (specify)		Month Day Year
P.0	that the de ned by the a detached	hys	9 Li Unknown			
	The law requires that tte has been signed b age 2 should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		co use contribute to the cause of death?
ord	w requires to been signer should be o	ted			1 ☐ Yes	2 No 3 Probably 4 Unknown
ec	has by	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E		Sol			performed 1 Yes 2 🗓	l? death? No 1 ☐ Yes 2 ☐ No
or Vital Records,	Physiclan: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other	th (Check only one)	
0	Phys this ral dir	은	1 ☐ Yes 2 ☐ No	TIL 3 DOA 4 I Nursing H	ome 5X Residence 28d. Describe how i	e 6 Other (Specify)
DO	Attending r death. ector: After by the fune	ioi	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		.,,.,,
Division	Atten deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, si	reet, factory, office	28f. Location (Stree	t and Number or Rural Route Number,
5	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	itare)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea			
	the Ho hin 24 the Fu npletel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.		area at the tille, date	and place, and due to the cause(s)
	To the Community	Σ	29b. Signature and title of cartifier	29c. License number	29d.	Date signed (Month, Day, Year)
			I Wille hs	026499	J	uly 9, 2009
1/12	5		30. Name and address of person who completed cause of death (Item 23a) (Type			0.1554
KB			21 Date filed (Month Day Vegr) 32 Registrar's Signature	1 Drive, Mount A	iry, Maryl	and 21771
b	Sta Regist		III 10 2008	borker		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Estelle Beall White 9:05 P M July 08 2009 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Severna Park 605 Thomas Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 88 Months Days Hours 425-18-7327 1921 Director Feb. 26, Mississippi Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Examinar must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 605 Thomas Way 21146 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Early Childhood Educator Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ant of Health and Mental H
tt: If item 27 is marked oth
y or other traumatic even Edwood Beall Elizabeth Jane Redmond ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger White / Son 527 King Malcolm Avenue Odenton, MD 21113 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other t 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 13, 1 N Burial 2 ☐ Cremation 3 N Removal from State Lumberton City Cemetery 2009 Lumberton, MS 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) eral Director: After this certificate has been signed by the ifilled in by the funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Box 68760 P.O. Division of Vital Records.

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only 29b. Signature and title of ce

4 Homicide

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

D41586

ted cause of death (Item 23a) (Type, Print)

8 21 Wi Benfield Rd, Severna Park, 4021146

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Medical

.MD ME551C5 naran 32. Registrar's Signature

Phy	sicia
/M	edica
Exa	ımine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it at Madical Extractional to toolified at any injury or other traumatic event, it at Madical Extractional to toolified at any injury or other traumatic and once.

Baltimore, Maryland 21215-0036 Physician /Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta Registrar

	Registrar				Cer	lilicate of	Deam		Reg. No.		40		
an al	1. Decedent's Name <i>(Firs</i> RICHARD		OKUM,	SR.				2. Date of De Month JULY	eath B ^{Day}	200	Year 9	3. Time of Dea	ath Рм
er	4a. Facility Name (If not li		•	HOSPIT	гат.	4b. City, Town, o		eath		County o		ERY	
	5. Social Security Number 235-72-67	er 6. Sex		e (In yrs. last t		If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi	rth		9. Birthp Coun	place (State or Fo htry) WV	oreign
tor		edent County MONTGON	MERY	10c. City, To		eation VILLE					1	0d. Inside City L	
al Direc	10e. Street and Number 19608 WE	STERLY	AVE.			10f. Zip Code 20837	7		10g. Citi	zen of W		itry?	
Completed by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 D	2 Married	. Was Decedent I Armed Forces? 1 Dres 2 □ N If Yes, Give Year or Dates:		- "	Vas Decedent of I Yes, specify Cub	dispanic Origin an, Mexican, P Specify:	? (Specify Yes or N uerto Rican, etc.)	0-		, White, e	ean Indian, etc.	
ompleted	15. C (Specify on Elementary/Secondary	Decedent's Educa nly highest grade of (0-12)	tion completed) College (1-4or 5		(Give I life. E	lent's Usual Occup kind of work done OO NOT use retire NESS OV	during most of d)	working		nd of Bus		dustry SUPPL	IES
To Be C	17. Father's Name (First, RICHARD J		YOKUM					Name (First, Middle ELEEN S			9)		
	19a. Informant's Name/R	/	o. Print) POUSE					r Rural Route Num E., POO					7
	20a. Method of Disposition 1 Burial 2 Cre 4 Donation 5	on emation 3 Rer	moval from State	20b. Place	of Dispos	sition (Name of natory or other pla N CEME!	ce)	Date	20c. Lo		City or To	wn, State	
	21. Signature of Funeral	Service Vicence			22 H	Name and Addre	ess of Facility FUNERA K 86,	L HOME BARNESV	LLE	, MI) 2	0838	
	23a. Part 1. Enter the dis shock, or heart failt Immediate Cause (Final disease or condition resulting in death)	ure. List only one	ations that caused cause on each lir	ne.		er the mode of dyi	ng, such as ca	rdiac or respiratory	arrest,			Approximate Interval Betwee Onset and Dea	en th
n/Medical Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns, b. atte c. d.	MULTI Due to (or as	a consequence ORGAN a consequence a consequence	FAI e of):	LURE							
ıysician/Me	IF FEMALE: 23b. Was decedent preg in the past 12 montl 1 Yes 2 No 9 Unknown	manii	c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea		Ectopic pregnand Other (specify)	су			23d. Date Mor		ery Day Yea	r
d by Ph	Part II. Other significant	conditions contr	ibuting to death be	ut not resulting	g in the ur	nderlying cause gi	ven in Part I.		tobacco (he cause of deat	
Completed by Physicia								24a. Wa auto per 1 □ Yes	opsy formed?	, d	Vere autorior to co eath?	opsy findings ava impletion of caus	ilable se of
Be (25. Was case referred to examiner?	_						Death (Check only	one)				
	1 Yes 2 No 27. Manyer of Death	☐ Pending	spital: 1 Inpatie 28a. Date of Inju (Month, Da	iry 28b	Outpatien Time of Injury	1 3 LI DOM	ry at	ng Home 5 Res			_ ` '	fy)	
Medical Certification: To	2 Accident	investigation Could not be determined	28e. Place of Injubulding, etc.	ury - At home, c. (Specify)	farm, stre	M 1 C]Yes 2□No	28f. Location	(Street an own, State	nd Numbe	er or Rura	al Route Number	,
dical Ce				f examination				place, and due to the occurred at the time					
Me	29b. Signature and title of	certifier	2	M	7	29c. Licen	se number	97	29d. Da	te signed	(Month,	Day, Year)	
	30. Name and address o			leath (Item 23:			ENTER	DR., ROO	CKVT	——↓ LLE	, MD	20850	-
te ar	31. Date filed (Month, Da		32 Registr	ar's Signature		Med		Lite / ROC	~1 V I.	ر بیی	,	20000	
001	JUL	10 2003	Consul	J B.	7800	J. Wall			·				

		1	For State Registrar			State of	ivia	ryiand		artmen rtificate			ina iv	ieniai m	Reg. No	6 U	09	243/0
Physic		ı	1. Decedent's Nam	ne (First, Midd	,	Yu Y	ee							2. Date of D Month July	eath Day		Year 2009	3. Time of Death 12:39 am
/Med		•	ła. Facility Name ((If not instituti						4b. City,	Town, or	Location of	f Death		4c.	County	of Death	
LAGIII			Shady	Grove I	lospit	al						Rockvi	11e				Mont	gomery
Funera	1	Ę	5. Social Security		6. Sex		7. Age	(In yrs. la	ast birthday)	If Under	1 Year	If Under 2	4 Hrs.	8. Date of B	irth			place (State or Foreign ntry)
Directo			218-19-		1 🕱	M 2□F		81	Yrs.	Months	Days	Hours	Min.	October	Day, Year)		Cour	China
yland how		ŀ	Jsual Residence o 10a. State	10b. Count	у			10c. City,	, Town or Lo	cation							1	0d. Inside City Limits
Mar a-f s	Ę		Maryland	Mont	tgomer	У					Pot	omac						1 ☐ Yes 2 🗷 No
h the	Director		10e. Street and Nu	umber						10f. Zip	Code				10g. Cit	tizen of	What Cour	ntry?
h wit			106	05 Farmi	rooke	Lane						20854					U.S.	A.
2 should be filed within 72 hours after death with the Maryland and Mental Higiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Maritial Evotrainer must be notified at	Fineral	3	11. Marital Status	riod 2000 Ma		2. Was Dece Armed For 1 ∐Yes	rces?		5. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	10-		ce - Americ ck, White,	
ours aff	2	5	3 Widowed			If Yes, Giv Year or Da	/e			1∐Yes 2	2 ⊠ No	Specify:				Specif	y:	Asian
72 h	4		(Spe	15. Decede	ent's Educ	ation completed)			(Give	dent's Usua kind of wor	k done d	lurina most	of worki	ing	16b. K	ind of B	usiness/In	dustry
within ene. than "	Completed		Elementary/Sec			College (1	-4or 5+)	`life. I	DO NOT us Fo		rvice					Chef	
filed Hygi			17. Father's Name	(First, Middle	e, Last)								r's Name	(First, Midd	le, Maiden	Surnar	ne)	
d be ental ced o	a B	i		Huan		Yee							Zh	ong Xi	ao Hu	ang		
hould Md Mark	٢	1	19a. Informant's N						19h Mailir	na Address	(Street a	and Numbe		al Route Num			State, Zic	Code)
d2s thar thar 7 is				i Yu - S		0.111111)				•				mac, Ma	-			, , , , , , , , , , , , , , , , , , , ,
1 an Heal em 2		T	20a. Method of Dis		JOII			20b. Pl	ace of Dispo					Date	-	-	- City or To	own, State
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er			1 🖾 Burial 2 4 🗆 Donaxion	Cremation		emoval from S	State		emetery, crer e of He			i	07/1 8	3/2009	Silv	er S	pring,	Maryland
o rmit.	- Sulo		21. Signature of F	Juneral Service	e License	e	,		18		inald	i Fune	ral H	lome, In				
		+	23a. Part 1. Inter shock, or he	A	or compli	ations that ca	್ aused t	the death.				-				prin	g, Mar	yland 20904 Approximate
Physicia	n		Immediate Cause disease or conditi	e (Final	st only on				uctive									Interval Between Onset and Death Years
/Medica Examine			resulting in death))		Due to (or as a	consequ	ence of):									
Pa ti	ing.		Sequentially list co if any, leading to in cause. Enter Und	mmediaté Jerlying	Į b	Due to (or as a	consequ	ence of):								100	
execute and	Evaminer	1	Cause (Disease o that initiated event resulting in death)	ts	С.	Due to (or as a	consequ	ence of):									
ifficate be executed g physician and as the burial-transit	adiral F	5			d													
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The law requires that the death cert are has been signed by the attending age 2 should be detached for use a	Physician/M		IF FEMALE: 23b. Was deceder in the past 12 1 \(\sum \) Yes 2	2 months? □No	23	3c. If yes, out 1 ☐ Live b 4 ☐ Pregr 9 ☐ Unkn	oirth 2 nant at	⊇ 🗀 Fetal	death 3	⊒ Ectopic p ⊒ Other (sp		/					ate of deliv onth	ery Day Y ear
that the dended by the detached	Phy		9 ☐ Unknow		tions			not rec	Iting in the	ndorluina -	aueo cir	an in Dest I		230 Di	t tobacco	use con	trihute to t	he cause of death?
uires the signer of the designer 2	2	Pneumon		uons con	tributing to de	aur bu	i noi resu	ining in the di	ndenying c	ause give	ann ranti.						bably 4 🔲 Unknown	
law requir as been s 2 should	ompleted		Pneumot	horax										24a. Wa		24b.	Were auto	opsy findings available
The la	i i													per	topsy rformed? ; 2 🕱 No	5	death?	ompletion of cause of 2 □ No
ician: The certificate ector, pag	R P)	25. Was case refe examiner?	erred to medic	al							26. Place	of Deatl	h (Check onl)				
ysic nis ce dire	Ē)	1 ☐ Yes 2 5	No No	Н	ospital: 1 🕱 I	Inpatier	nt 2 🗆 E	ER/Outpatier	nt 3□DC	Othe	er: 4 □ Nu	rsing Ho	me 5 □ Re	sidence	6 □Ot	her (Speci	(fy)
ding Pl	Certification.		27. Manner of Dea	5 🔲 Pend	ling stigation	28a. Date (Mont	of Injur th, Day,	Year)	28b. Time o Injury	f 2	8c. Injur Work	yat <br Yes 2 ∐ 1		28d. Describ	e how inju	iry occui	rred	
Atten r deat ector; by the	ifica		2 Accident 3 Suicide 4 Homicide	6 ☐ Coul		28e. Place	of Inju	ry - At hor	me, farm, str	eet, factory				28f. Location	(Street a	nd Num	ber or Run	al Route Number,
ital or urs afte ral Dir								(Specify							own, State			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p	le di le		29a. Certifier (Check only one)			ician: To the ner: On the b and man	asis of	examinat										stated. to the cause(s)
To th Vithir Comp	Mo		29b. Signature and	d title of certif	ier	11				290	. License	e number			29d. Da	ate signe	ed (Month,	Day, Year)
2			1 /08	MINA	70.	A1/ 1	70				D	53317					July 1	3, 2009
			30. Name and add	•														
				A. Ball						#213,	Gait	hersbu	rg, N	laryland	20877	7		
S Regis	State strar		31. Date filed (Mo	onth, Day, Yea				r's Signat	lure	W. S								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State AMEND ITEM #7 KB/FCHD Certificate of Death 07/09/2009 Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J_{u1y}^{Month} Angela M . Zurita 06. 2009 7:20 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mount Airy Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 23 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Year) Ecuador 1 □ M 2 F Months Days Hours 077-40-3307 84 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Director Maryland Frederick Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3677 Byron Court 21704 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1⊠Yes 2∐No Specify: Ecuadoran White Specify: 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jorge Solorzano Clemencia Paladines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Zurita / Son 3677 Byron Ct. Frederick, MD 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July Date 7. 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State Resthaven Crematory | 2009 4 Donation 5 DOther (Specify) Frederick, Maryland Resthaven Fulleral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick. MD 21701 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Care (Final MULTINE ELOMA disease or condition resulting in death) Due to (or as consequence of): Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a sonscauence offresulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? Yes 2. ██No 1 □ Yes

/Medical Examiner requires that the death certificate be executed use as the burial-tran Box 68760, physician attending p P.0. been signed by the should be detached Division of Vital Records, this certificate has ral director, page 2 : To the Hospital or Attending Physician: After thi funeral of death. ours after death.

neral Director: /

Physician

/Medical

Examiner

Funeral

Director

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examit or must be notified at

12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r

permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is 1
any injury or other trau

Physician

Examiner

Physician/Medical

ð

Completed

Certification:

Medical

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Housing 1034 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated

5 KB

within 24 hours a

To the Funeral I

completely filled

State Registrar

29b. Signature and title of certifier

4.0. DIRECTOR; 516 TRAIL ASDICAL Registrar's Signature

DIRECTOR

LIGOICAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D10587

HOSPICE OF FREDERICK

29d. Date signed (Month, Day, Year)

COUNTY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene...

			1 - State Registrar	-	Certificate of I		, ,	eg. No. 2009	24372
П	Dhuniai		Decedent's Name (First, Middle, Last)	*			2. Date of Deal	- 14	3. Time of Death
	Physicia /Medic		Lewis Martin Bish Sr.				July	30°, 2009	
1	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or White	Location of Death		4c. County of Dea	
_ AR	Euporal	-	4327 A Cooper Road 5. Social Security Number 6. Sex 7. Age	(In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		thplace (State or Foreign
	Funeral Director		217-24-9127 ¹ X ^M 2□ F		Yrs. Months Days	Hours Min.	April 1	9,1930 Ma	ryland
	yland Now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	a-f sk	ctor	Maryland Harford		Whiteford				1 ☐ Yes Z∕ No
	or 28	Dire	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What Co	ountry?
	ath w	ral	4327 A Cooper Road		21160			USA	
	items	-une	11. Marital Status 12. Was Decedent E Armed Forces? 1 □ Never Married 2 Married 1 MYes 2 □ N		13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
036	al", or	by	3 ☐ Widowed 4 ☐ Divorced	1954	1 □Yes 2MNo	Specify:		Specify: W	hite
2-0	72 hor	eted	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occup (Give kind of work done of	during most of work	ina I	16b. Kind of Business	/Industry
Maryland 21215-0036	be filed within 72 hours after death with the Maryland the Hylylene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, I've Medical Evaninar must be notified at	Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4or 5-	-)	Paint Maker	1)	9	Paint Man	ufacturer
2	filed w Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Last)		Taint taker	18. Mother's Name	e (First, Middle, I		uracturer
an	ld be lental ked o ic eve	To Be	John Bish			Anna	Matuk		
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street			r, City or Town, State,	Zip Code)
Σ	and 2 ealth: n 27 I		Mildred Koch, Wife		27 A Cooper				
ore	ges 1 t of H if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State		Disposition (Name of y, crematory or other place			20c. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menthel Hygiene. Important: If them ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify)		Crematory I				, Maryland
Ba	Depa Impo any i		21. Signature of Funeral Service Licensee Thomas	regor	Cremation 299 Frede	ssociety rick Road	Of Mary Baltim	land, Inc. ore, Maryl	and 21228
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin-	the death. Do n					Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition		unknour	Dame	ans		MCHT Death
1	/Medical Examiner		resulting in death) Due to (or as a	consequence of	of):				
	Zammer	e.	Sequentially list conditions, b.	i consequence o	die.				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Concequence					
oʻ	an an		resulting in death) Last Due to (or as a	consequence o	of):				
68760,	rificate be executed ig physician and as the burial-transit	edical	d						
			IF FEMALE: 23c. if yes, outcome of	of pregnancy				2018	
P.O. Box	attendin for use a	Physician/N	in the past 12 months?	2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of de Month	Day Year
Ö.	t the c by the ached	hysi	1 Yes 2 No 9 Unknown 9 Unknown		,,,				
S, F	es tha gned se det	by P	Part II. Other significant conditions contributing to death bu	t not resulting in	the underlying cause give	en in Part I.		bacco use contribute t	
ord	w require been si should t						1 U Y	es 2 No 3 F	Probably 4 Unknown
Division of Vital Records,	1 23 a	Completed					24a. Was a autops perfor	sy prior to med? death?	utopsy findings available completion of cause of
ta	ding Physician: The I h. After this certificate ha funeral director, page	Be C	25. Was case referred to medical			26. Place of Deat		2 [No 1 ∐ Ye ne)	s 2XNo
<u>×</u>	hysic this ce Il direc		examiner? 1 Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Out	tpatient 3 DOA Oth	er: 4 🗆 Nursing Ho		ence 6 ☐ Other (Sp	ecify)
on C	ding P	<u>io</u>	27. Manper of Death 1 Natural 5 Pending 28a. Date of Injur (Month, Day	y 28b. T ; <i>Year)</i> Ir	ime of 28c. Injur njury Worl M 1 □	k?	28d. Describe h	ow injury occurred	
Sic	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju	ry - At home, far	m, street, factory, office	Yes 2 □No	28f. Location (S	treet and Number or F	Rural Route Number
2	al or / s after il Dire	Certification: To	4 ☐ Homicide determined building, etc	(Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Tow	n, State)	
	Hospit Houn Funera tely fille		29a. Certifier (Check only) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of	examination and	, death occurred at the tild d/or investigation, in my o	me, date and place opinion, death occur	, and due to the or red at the time, or	cause(s) and manner a	as stated. le to the cause(s)
	o the vithin 2 o the omple	Medical	one) and manner sta 29b. Signature and title of certifier	ted.	29c. Licens	e number	2	29d. Date signed (Mon	th, Day, Year)
	- s - ó			ıl.					
	ofly		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Print) 5.00	enst	Barth	more, M	021201.
×	Sta	te		r's Signature					
	-412		JUL 3 0 2009 Brown	2 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month -39 PM **Physician** arahona 2009 exan der JUC /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/AThe Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 F Maryland May 3, 2008 217-81-5160 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show must be notified at 1 Yes 2x No Director Lutherville Timonium Baltimore Maryland death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code items 23a Court 21093 United States 2 Breezy Tree Apartment A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify Specify: ģ 3 Widowed 4 Divorced Salvadorian Hispanic "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) n and Mental Hygiene. N/A Never Worked 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tina Santos Barahona Madison မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important; If item 27 is
any injury or other trai 2 Breezy Tree Court Apt. A, Lutherville-Timonium, Maryland 21093 Tina Barahona/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State July 28, 2009 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory, Inc. of Funeral Service Upensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 055 disease or condition resulting in death) /Medical Due to (or an a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 \square Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home Hospital: 1 ☐ Yes 2 No 1.2 Inpatient 3 🗌 DOA 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) မှ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After t 5 Pending investigation (Month, Day Year) 1 Natural Injury 1 Tes 2 No 2 Accident Director; / 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide after City or Town, State) within 24 hours a To the Funeral C completely filled 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

/

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

3 0 2009

Noter

82. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Approximate Interval Between Onset and Death

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2X No

North Carolina

10:30P M

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

REMIN Due to (or as a consequence of) p 81 5

> 23d. Date of delivery Month

IF FEMALE

Physician/Medical

≥

Completed

Be

Certification: To

Medical

1 - For State Registrar

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No

2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death?

1 □ Yes 2 □ No

Year

25. Was case referred to medical 1 ☐ Yes 2 ☑ No

27. Manner of Death

1 Natural

29a. Certifier

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Injury

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Reg. No.-

2009

Montgomery County

14. Race - American Indian. Black, White, etc.

Specify: White

16b. Kind of Business/Industry

U.S.Dept.Commerce

20c. Location - City or Town, State

Sarasota, Florida

4c. County of Death

10g. Citizen of What Country?

U.S.A.

Fisher

28d. Describe how injury occurred

1 Tes

24a. Was an autopsy performed? Yes 2 110

1 ☐Yes

investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

title of certifier 29b. Signature an Hannin

5 Pendina

29c. License numbe D-50284

State

Registrar

SHALLED CHAMIM, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WASHINGTON ADVENTIST HOPPITAL, TAMOMA PARM, MD-20912 32. Registrar's Signature

DHMH 17 Rev 1/2001

physician

After this certificate has been signed by the a funeral director, page 2 should be detached f

After this

within 24 hours after death

To the Funeral Director: completely filled in by the f

within 2 To the I

death.

Box 68760,

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 12:55 AM July 22, 2009 Violet Mae Baker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Village Care & Rehab Montgomery Village Montgomery 8. Date of Birth (Month, Day, Yea Feb. 11, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Year) 1930 Pennsylvania 1 □ M 2 🖔 F Months Days Hours Min. 165-24-7276 79 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Moderal Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Pygiene. U.S.A. 20877 100 Oakton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛱 No 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) grade completed) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Nursing Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Dull Charles Lester Sipes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Oakton Rd., Gaithersburg, MD 20877 Elesia L. Baker (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1:
Department of He
Important: If iten
eny Injury or oth Date 20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State Everett Cemetery 7/25/09 Everett, PA 4 Dopation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Dalla Valle Funeral Service, 22 W. Main St., Everett, PA 1 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Recent Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-transit Congestive Heart Failure Due to (or as a consequence of): Box 68760, Physician/Medical End Stage Cardiomyopathy IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a O 9 Unknown 9 Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy certificate 1 □Yes 2 X No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ို After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 1 ី Natural 5 Pending investigation after death.

Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a

To the Funeral D Hospital 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WD July 23, 2009 D 41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctor's Dr., Germantown, MD 20874 Vinu Ganti, MD Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 29 Registrar

			1 – For State Registrar		f Maryland		artmen rtificate			and M		Reg. No	109	24376
	Physici	an	1. Decedent's Name <i>(First, Midd</i> Maria	le, Last)		Bell	as				2. Date of Dea Month July	ath 289	Ž009	3. Time of Death 4:00P M
4	/Medio		4a. Facility Name (If not institution	n, give street and nu	mber)			Town, or	Location	of Death			nty of Death	
	Exami	iei	Heart Homes As	-			Lin	thic	um -			Anne	Aruno	del
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🗓 F	7. Age (In yrs. la 88		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h y, Year)	9. Birthp	lace (State or Foreign
	Director		217-50-8592	1 □ M 2 AJ F	00	Yrs.	Months	Dayo	110010		June 5	, Year) 1921	It	aly
	and w		Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Lo	cation						1	0d. Inside City Limits
	Maryl -f sho	ţō	Maryland Anne	Arundel C	Co. Se	evern								1 □Yes 2 No
	r 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	f What Cour	ntry?
	h with	a D	8327 New Cut	Road					2114	4		Unit	ed St	ates
	ems.	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S	. 13.	Nas Deced	lent of Hi	ispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	- 14. R	ace - Americ	
36	or it		1 Never Married 2 Mar	rried 1 □Yes If Yes. Gi	2 ∑ No ve		1 □Yes 2		Specify:		, , , , , ,		ify: Whi	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Evaninas must be notified at	Completed by	3 ⅓ Widowed 4 □ Divorced	Year or D	ates:	16a. Dece	dont'e Heus	I Occup	ation			16b. Kind of		
7.	in 72 n "na"	plet	(Specify only highe	est grade completed)		(Give	kind of wor DO NOT us	k done a e retired	during mos l)	t of worki	ing	TOD. KING OF	Dusinessini	austry
212	d with giene rr tha	E O	Elementary/Secondary (0-12)	College (*		Pro	fessi	ona1	L Art	ist		Ä	\rt	
nd	ould be filed within I Mental Hygiene. narked other than natic event, ir un	Be C	17. Father's Name (First, Middle	Last)					18. Mothe	er's Name	(First, Middle,	Maiden Surn	ame)	
yla	should b and Ment s marked umatic e	은	Giuseppe DeMar	со					Este	r Ra	tti			
<u>~</u>	and s n		19a. Informant's Name/Relations					•			al Route Numbe	-		
o)	1 and 2 Health tem 27 i		Mr. Robert A	Bellas / S	on on pr		6 Col				Glen B	20c. Locatio		and 21061
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot		1 ☐ Burial 2 ☐ Cremation	3 Removal from	State I	ace of Dispo metery, crei			i				•	
Ħ	nit. Pa artme ortani injury		4 ☐ Donation 5 ☐ Other (5		ment Ce		ill C 2. Name an				1/2009			
Ba	permit. Departn Importa any inju		1100	5/	M01121	ļ.				٠.	_			Cremation, MD 21061
			23a. Part 1. Enter the disease, o	r complication that c	aused the death.									Approximate Interval Between
L	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one cause and	Chark	160	K	dh	eu	Ca	uper-			Onset and Death
	/Medical		resulting in death)	Doe to	(or as a conseque	ence of):		1	1					
	Examiner	ایا	Sequentially list conditions,	b					Э.К.					
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conseque	ence of).							1	
	execu al-trar	хап	that initiated events resulting in death) Last	c	(or as a conseque	ence of):								
68760,	ate be executed hysician and the burial-transit	cal		d										
.89	tificat ig phy as the	edi		u										
Вох	eath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnan		∃Ectopic pr	reanancı	ı,			1	Date of delive	•
). B	e deal	sicis	in the past 12 months? 1 □Yes 2 □No		nant at time of de		Other (sp		y 			'	Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown	0 -0000		ain n in ab n			an in Dani I		220 Did t	abana usa as	merihusa ta ti	ne cause of death?
ds,	ires th signe I be d	þ	Part II. Other significant conditi	ons contributing to d	eam but not resul	ung in ine u	idenying ca	ause give	en in Part i		1 🗆 1	1		pably 4 Unknown
Sor	w requir been s should	etec												
Records,	: The law cate has , page 2 s	Completed									24a. Was autor perfo	an 24 sy rmed?	prior to co death?	psy findings available mpletion of cause of
Vital	Ician: Th certificate ector, pag		25. Was case referred to medica	al I					DC Disease		1 □ Yes	2 HVO	1 🗆 Yes	2.000
>	yslcie is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 2 5		nt 3 🗆 DO	Othe	or:		n <i>(Check only o</i> me 5 ☐ Resid		ther (Specif	Heart
οl	ig Phr ter thi	Ë	27. Manner of Death	28a. Date		28b. Time o Injury		8c. Injury Work	y at		28d. Describe I	_		y Homes
ioi	ending eath. or: After he funer	atio	E L. Modidoni	igation	in, Day, reary	injury	М		Yes 2 🗆	No				
Division	or Atter de lirecte n by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	nined 286. Place	of Injury - At hor ing, etc. (Specify)	ne, farm, str)	eet, factory,	, office			28f. Location (3 City or Tox	Street and Nu vn, State)	mber or Rura	al Route Number,
Ω	Hospital or Attending Physician: The law requires that the death certificate be executed Anours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit		20-0-15-											
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		ng Physician: To the Examiner: On the b										
	To the within 2 To the comple	Me	29b. Signature and title of certific	1)	nor stated.		29c	. License	e number	_		29d. Date sig	ned (Month,	Day, Year)
	->-0		beent.	plot "	M			02	009	4		071	29/0	8
			30. Name and address of person	who completed caus	of death (Item	23a) (Type,	Print)		0, 11	IN	0 (1 6	7	1
			Ellet 400	way M.	1, 1411	ay	adio	toh 1	LMK	11/	W be	en 101	Mul	md, 2106/
	Sta Registr		31. Date filed-(Month, Day, Year,	189 And	segistrar's Signati	are fau	es!				(')
	3		ANT O A T	ver per	-	(1								_

July 30, 2009

2437

Physicia /Medica Examine

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic event, the Medical Examinar must be notified at any once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

State Registrar

30. Name and address of person who con

Registrar		Cei	tificate of	Death	R	eg. No.	7 6 701
1. Decedent's Name (First, Middle, La	ast)				2. Date of Deal		3. Time of Death
Thurman A. Bartl	h				July 28		8:35 p
4a. Facility Name (If not institution, given	ve street and number)		4b. City, Town,	or Location of Deat	h	4c. County of [Death
Dove House - Hos	spice		West	minster		Carro	11
5. Social Security Number 6.	Sex 7. Age ((In yrs. last birthday)	If Under 1 Yea Months Days			Year) 9.	Birthplace (State or Forei Country)
214-38-5324	1 ½ M 2□ F	69 Yrs.	Months Bay	Tiodio Willia	09/12/		MD
Usual Residence of Decedent	14	0- 0't- T					40d Innido City Limi
10a. State 10b. County		Oc. City, Town or Lo					10d. Inside City Limit
MD Howard	d	Ellicot					**
10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
9584 Old Route 10	08		21	042		United S	tates
11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13. \	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc.
1 ☐ Never Married 2 ☐ Married	1 □Yes 2 X No If Yes, Give		l∐Yes 2∐Mo		,	Specify:	White
3 ☑ Widowed 4 ☐ Divorced	Year or Dates:			-,,-		opeany.	MITTE
15. Decedent's E (Specify only highest gro	ducation ade completed)	(Give	lent's Usual Occ kind of work don	e during most of wo	rkina I	16b. Kind of Busin	ess/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use retii	red)			
10		Pes	t Manage	ement Spec		Self-Em	ployed
17. Father's Name (First, Middle, Last	t)			18. Mother's Nar	me (First, Middle, i	Maiden Surname)	
Roland A. Barth	ı			Doroth	y M. Sull	ivan	
19a. Informant's Name/Relationship		19b. Mailin	g Address (Stree	et and Number or R	ural Route Numbe	r, City or Town, Sta	ite, Zip Code)
Dorothy A. Harma	n – sister	9584	Old Rou	ite 108 I	Ellicott	City, MD	21042
20a. Method of Disposition	_	20b. Place of Dispo- cemetery, cren	sition (Name of			20c. Location - City	
1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	□ Removal from State	Woodlawn		1	01/2009	Woodlawn	MT
21. Signature of Funeral Service Lice		1044 22	. Name and Add	ress of Facility	01/2005	t-lI F	amily F.H.In
St. alla	~ 10766.	1044	112 013	Columbia	Diko Eli	tzke's F	amily F.H.In
23a. Part 1. Enter the disease, or com	nplications the caused th						Approximate
shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1 10,100	1	ying, odon do odrala	io or roopilatory an	551,	Interval Between Onsettand Death
disease or condition resulting in death)	a	IVUIV	4011				Iwn
resulting in death)	Due to (o as a c	consequence of):		DIE.	10 D. A	10/10	1. 1.
Sequentially list conditions,	b. CLL)2/4CM	ch	MACI	Le VIIO	1 most	lan
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a d	consequence of):	000	^			1
that initiated events resulting in death) Last	c. / ()	Neigh	peut	'			1 hh
resulting in death) Last	Due 🐧 (or as a d	consequence off):	1				
•	d						
IF FEMALE:							
23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2	pregnancy	Ectopic pregna	ncv		23d. Date o	
in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at til	me of death 5	Other (specify)	,		Month	Day Year
9 Unknown	∌ □ Uliknown						
Part II. Other significant conditions	contributing to death but r	not resulting in the ur	nderlying cause o	jiven în Part I.	23e. Did to	bacco use contribu	te to the cause of death?
7 mory serva					1 □ Y	es 2 No 3	Probably 4 🗆 Unknow
7					24a. Was a	n 24h Wer	e autopsy findings availab
					autops	sv prio	r to completion of cause o
							Yes 2□No
25. Was case referred to medical examiner?	Hospital				ath (Check only or		
1 Tes 2 No	Hospital:		t 3 DUA				(Specify)Hospice
27. Manner of Death 1	28a. Date of Injury (Month, Day,)	28b. Time of Injury	W	ury at ork?	28d. Describe he	ow injury occurred	
2 ☐ Accident investigation			M 1	□Yes 2□No			
3 ☐ Suicide 6 ☐ Could not be determined		- At home, farm, stre	et, factory, office		28f. Location (S. City or Town	treet and Number o	or Rural Route Number,
	25	,			0.0, 0, 1000	.,)	
29a. Certifier 1 Certifying P	hysician: To the pest of	my knowledge, death	occurred at the	time, date and place	e, and due to the o	ause(s) and mann	er as stated.
(Check only 2 Medical Exa	miner: On the basis of e	xamination and/or in	vestigation, in my	opinion, death occ	urred at the time, o	late and place, and	due to the cause(s)
20h Signature and title of certifier		/	200 1	noo number		20d Data signed (A	446 D \(\alpha\)

DHMH 17 Rev 1/2001

555 S. Center St. Westminster, MD 21157

npleted cause of death (Item 23a) (Type, Print)

gistrar's Signature

			Ple	ase Type or Prin					-	_	e.
			For State Registrar	State of Ma	-		ment of F ficate of		mentai Hy	glene Reg. No. 200	9 24378
	Physical		1. Decedent's Name (First, Midd	fle, Last)					2. Date of De	eath	3. Time of Death
	Physici /Medio			l Blosser S					July	27 2009	1
	Examin	er	4a. Facility Name (If not institution 309 Locus)	_		4t	c. City, Town, o Esse	r Location of Deat	h	4c. County of D	
-	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. last birt		Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth 9.	Birthplace (State or Foreign Country)
	Director		234-32-8262	1 X M 2□ F	84	Yrs.	lonths Days	Hours Min.	Jan.1	7 1925	WVA
	land ow		Usual Residence of Decedent 10a. State 10b. Count	y	10c. City, Town	or Locati	on				10d. Inside City Limits
	a-f sh	ctor	MD Bal	timore		Es	sex				1 □ Yes 24€ No
	th with the 23a or 28 1st be not	al Director	10e. Street and Number 309 Locust	Avenue		1	10f. Zip Code	21221		10g. Citizen of What	: Country?
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaning must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 ※ Widowed 4 □ Divorce	If Yes Give	1		Decedent of Fes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race - A Black, W Specify:	American Indian, /hite, etc. White
5-0	72 hor	eted	15. Decede	nt's Education est grade completed)	16a.	Decedent	t's Usual Occup	ation during most of wo	rkina	16b. Kind of Busine	ess/Industry
121	vithin sne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		NOT use retired ROT use retired	during most of wo d) nder	9	GM	
d 2	filed v Hygie other t		12th 17. Father's Name (First, Middle	, Last)					ne (First, Middle	, Maiden Surname)	
'lan	Aental Aental rked c	To Be	Thornton 1	3losser				Nell:	ie Nich	nolson	
Maryland	2 shows and heart is ma		19a. Informant's Name/Relation							per, City or Town, Sta	
	1 and Health em 27 ther to		Russell Blo	sser Jr. /					d Balt:	imore MD 20c. Location - City	
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any Injury or othe		1 ☐ Burial 2 ☐ Cremation				on (Name of ory or other place Cremat	cory 7/		Baltimo	
altir	mit. Poartme		4 □ Donation 5 □ Other (21. Signature of Fineral Service		Dayv		ame and Addre				Balto. MD
Ä	Depa Impo any I		MATH IN INC.	akobe)	Co	nnelly	Funer			sex 21221
and the	Physician /Medical		23a. Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	or complications that caused to only one cause on each li	d the death. Do note.		he mode of dyli	ng, such as cardia		arrest,	Approximate Interval Between Onset and Death
-St	Examiner		,	Due to (or as	a consequence of	of):					
	uted I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a consequence o	of):					
, 0	icate be executed physician and the burial-transit		that initiated events resulting in death) Last	c Due to (or as	a consequence o	of):					
68760,		dical		d							
O. Box 6	or Attending Physician: The law requires that the death certificate affect. Iffer death. Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death		ctopic pregnand ther (specify) _	у		23d. Date of Month	delivery Day Year
ds, P.	uires that signed b	þ	Part II. Other significant condit	ions contributing to death b	out not resulting in	the under	rlying cause giv	en in Part I.			te to the cause of death? Probably 4 Dunknown
Vital Records,	law requir as been s 2 should	Completed							24a. Was		e autopsy findings available
Ä	: The lav cate has page 2 :	mo							auto perfo 1 □ Yes	ormed? deat	to completion of cause of h? Yes 2 □ No
/ita	sician: The certificate h irector, page	Be (25. Was case referred to medic examiner?				Lout		ath (Check only	one)	
of \	Physi r this c ral dire	.T	1 Yes 25 No 27. Manner of Death	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	tpatient :		4 □ Nursing r		idence 6 Other (Specify)
on	nding F tth. : After e funera	ation	1. Natural 5 ☐ Pend		iy, Year) Ir	njury	28c. Injui Wor M 1 🗆	k? Yes 2 □ No	Zud. Describe	now injury occurred	
Division	Il or Attendi after death. Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	I 286. Place of in	ury - At home, far ic. (Specify)	rm, street,	factory, office			(Street and Number own, State)	r Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 2 Medica	ing Physician: To the best il Examiner: On the basis of and manner st	of examination an	, death od d/or inves	ccurred at the ti tigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) and manne , date and place, and	er as stated. due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifi				29c. Licens			29d. Date signed (M	
	. 6		helden 1	hiner MD			018	598		7/28/0	19
_	121			rmo 9	death (Item 23a) (Type, Prin	delphi	a Ref	212	37)	
	Sta Registr		31. Date filed (Month, Day, Year JUL 2 9 20) Several 32. Registr	rar's Signature	de	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yeer Month **Physician** 12:30 P.M Mary Rosaria Baxter July 23 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Emmitsburg St. Vincent Care Center 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funera! Davs Hours 1 □ M 2 🕅 F 68 153 30 5236 11/01/1940 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

In mortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Experience makes once. 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 1 No Be Completed by Funeral Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21227 4100 Maple Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Years Elementary/Secondary (0-12) Administer Religious 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Patrick Baxter Nora Brigid Quinn ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21227 4100 Maple Avenue Sister Mary Regina Long 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/28/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 234. Part 1. Enter the disease, or compilerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 12a1 /Medical Examiner ein Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🕱 No Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number (Type, Print), 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Year Month **Physician** PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County, of Death Examiner 586 CYNWOOD albo HOSPIC EASTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6 Sex **Funeral** 1 □-M 2 □ F Months Days Hours Min. MIchigan 65 379-44-116C 11-10-Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination and be notified an once. 1 Tes 2 No Director Easton 91100 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 29170 Woodridge Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 176-90 1 ☐Yes 2X No Specify: Specify: δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) religion minister 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fern Elaine Richey Milton Harold Bank ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29170 Woodridge Drive Easton, MD Cathy Miller/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Services State Andromy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part 1. Enter the disease, of complecations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal cell careerona with metastatus **Physician** disease or condition resulting in death) /Medical disease to the lungs, hive Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached for P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 M 1 ☐ Yes 2 No 1 □Yes Be (26. Place of Death (Check only one) 25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice 1 | Yes 2 De 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deam.

To the Funeral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 7/24/2009 29b. Signature and title of cartifier 29c. License number 2 12124198 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

S. E. Delen - Botten, Charles - 8579 Commerce Du, Sickerul, Easte MS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUL 29 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death Decedent's Name (First, Middle, Last) 25^{Day} July 2009 **Physician** Lee Edward Casev 4:23 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Brinton Woods Svkesville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6 Sex **Funeral** Months Days Hours 1 X M 2 □ F 88 December 21,1920 Indiana 316-01-5109 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f shov 1 ☐Yes 2XXNo Director Maryland Carroll Svkesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or items ury or other traumatic event, the Mexical Examiner must be not 21784 U.S.A. 1442 Buckhorn Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Staff Sergeant U.S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Casper L. Casey Barbara Schaffer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 568 Montaigne Court Calabash, North Carolina 28467 Jerry Casey (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Atlantic Crematory 7-29-2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Lioux 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Inc. Columbia, Maryland 21045 23a. Part 1. Errier the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (r as a conse juence o) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) certificate has been signed by the rector, age 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 14No 1 □ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 □No 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiners On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated within 2 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RNG UD SUITE

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25^{Day} **Physician** 2ŎÔ9 July8:00 P.M Oscar Edmund Campbell /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 10754 Autumn Splendor Drive Columbia If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 391-40-4098 June 12, 1928 South America Director 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, In Product Exercipes must be recipied at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Director Columbia Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21044 10754 Autumn Splendor Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2**∑**No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2X Married 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 👿 No Specify. Specify: **Black** 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Mechanic Eastern Airlines Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dora Branch Frederick Campbell ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria E. Campbell (Wife) 10754 Autumn Splendor Drive Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place)
Columbia Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial , 2 ☐ Cremation 3 ☐ Removal from State 8-2-2009 Clarksville, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service Licens Inc. Columbia, MD 21045 23a. Part 1. Let the disease or complications in 1 caused the death. shock, or heart failure. I st only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Oneet and Death Immediate Cause (Final ero **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No I∐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 ₩o Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b: Sign 29d. Date signed (Month, Day, Year) (Type, Print), ate filed (Month, Day, Year) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 27 Ju₁y 2009 11:05a Marie Dolores Cashman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5409 Lighting View Way Howard Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, August 14, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 🕱 F Delaware 73 Director 134-28-4358 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 K No Director Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5409 Lighting View Way 21045 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify. Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Policy Analyst Medicare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Donovan Marie Quinn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) 5409 Lighting View Way Columbia, MD 21045 Daniel Cashman 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Louis Church Cemetery 8-3-2009 Clarksville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Witzke Funeral Homes 5555 Twin Knolls Road Columbia, Maryland 231045 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NO VO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for a Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home SY Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending М 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGODDA 31. Date filed (Month 32. Registrar's Signature State Registrar

		For State Registrar	State of Mary		rtificate of		wentai Hy	/giene_ Reg. No.	UJ	24304
Physicia /Medic		1. Decedent's Name (First, Middle, Last, FRANCES ELIZAI		LER			2. Date of Do Month July	eath 23, 2009	Year)	3. Time of Death 12:10 A M
Examin		4a. Facility Name (If not institution, give Manor Care - Tows			4b. City, Town, or Towson	r Location of Death	1	4c. Count	y of Death Lmore	
Funeral Director		5. Social Security Number 6. Sec. 123–50–5793	7. Age (In	yrs. last birthday) 1	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, D	irth Pay, Year) 31, 1907	Cou	place (State or Foreign ntry) rginia
show	_	Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Lo	cation			-		10d. Inside City Limits
r 28a-f	Director	MD Baltimor 10e. Street and Number	e	Towson	10f. Zip Code			10g. Citizen of	What Cou	
23a o	ralD	900 Stags Head Ro			21286			USA		
illed within 7.2 hours arise death with the Maryano Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the medical Ever, increment by redifficed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🛭 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		ce - Ameri ack, White, fy: Wh:	
ene. than "natur iv Mudical.	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired al Clerk	during most of wor d)	rking	US Post		
ental Hygie ed other i	Be	17. Father's Name (First, Middle, Last)	4	1056	ar Glerk	18. Mother's Nan				state
z snould h and Me is mark raumatic	2	William A. Smith 19a. Informant's Name/Relationship (7)	· · · · · · · · · · · · · · · · · · ·		ng Address (Street	and Number or Ru				p Code)
permit. Fages I and 2 should be filed within 72 hours after death with the Warylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Ever, incl. inst by rediffice and once.		Rosalie Antos - N 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	2	0b. Place of Dispo	natory`or other plac V iew	i	Date	MD 212 20c. Location Prince County	- City or To	iam
Departm Importal any Inju once.		21. Signature of Funeral Service Licens	andlo	2:	y 2. Name and Addre 609 Cente	ss of Facility Pi	erce Fu	neral H	ome	
hysician /Medical		23a. P. 11. Fiter the disease, or complete fock, in heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	death. Do not en		ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
xaminer	al Examiner	Ecquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co Due to (or as a co Due to (or as a co	nsequence of):	PATH	У.				Years
by the attending physiached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other <i>(specify)</i> _	y			ate of deliv	very Day Year
n signed by	ð	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.		tobacco use coi]Yes 2 ☐ No		the cause of death? bably 4 7 Unknown
cate has been s page 2 should	Completed							opsy formed?	prior to co death?	opsy findings available ompletion of cause of
certificate irector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	lospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	ot all poal Oth	26. Place of Dea		one) sidence 6 □O	than (0	***
Average in strength of the raw requires that the death bear regard of the attending ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Ye	ar) 28b. Time o	f 28c. Injui Wor M 1 🗆		28d. Describe	e how injury occu	ırred	Line and the
within 24 hours after death To the Funeral Director: completely filled in by the f		4 ☐ Homicide determined	28e. Place of Injury building, etc. (S				City or To	own, State)		al Route Number,
thin 24 hc	Medical	(Check only 2 Medical Examone)	sician: To the best of m ner: On the basis of exa and manner stated.	amination and/or ir	vestigation, in my	opinion, death occi	urred at the time	e, date and place	e, and due	to the cause(s)
Note that the second se		29b. Signature and title of certifier	elm empleted cause of death of Daniel San Registrar's:	/llom 02=) /T-	Drint)	2849		7-2	3 6	04
		30. Name and address of person who of	empleted cause of death	(Item 23a) (Type,	Print) LER 1	Dr. 70.	WSCN	MD	21	204
Sta Registr	_	31. Date filed 11 th, 2 9 7 2009	Denegal 1	d. par	Les .					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year BRADLE CARVER 2:50 AM JULY 9 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Hospital Harbor 9. Birthplace *(State or Foreign Country)* Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 1 ÅM 2 □ F Months Days Hours 213-64-1108 53 06-22-1956 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location MD 1 ☐Yes 2 ☐ No Howard Elkridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6900 Ducketts Lane 21075 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No White If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 🖾 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator 12 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas C. Carver Ju1e More 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 370 Hunner Road Mr. James Folkemer / Executor Pasadena, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 III Cremation 3 ☐ Removal from State Atlantic Crematory 07-30-2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1 2nd Avenue SW 21. Signature of Funeral Service Licensee Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Due to (or as a consequence of): atic Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical

attending physician for use as the buria

i signed by the a d be detached f

page 2 should

funeral director,

After this certificate

To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

Physician/Medical

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Completed

Be

Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examiner ner The law requires that the death certificate be executed burial-transi Exami and

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

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Completed

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th and Mental Hygiene.
?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exercities must be notified at

hours after death

filed within 72 h I Hygiene.

permit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event, once.

3altimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical

1∐Yes 2 No

examiner?

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

autopsy 1 ☐ Yes 2 No

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA

Hospital: 1 npatient 28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? 28b. Time of

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number RES 001

ST.,

29d. Date signed (Month, Day, Year) 29,

BALTIMERE MD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARAL ANUPA 3001 S 31. Date filed (Month, Day,

HANOVER 2. Registrar's Sign

State Registrar

			_ For	State of Ma		/ Depa	artment of I	Health and I		_	e.
			1 - State Registrar			Ce	rtificate of	Death		leg. No.	9 24380
	Physic		1. Decedent's Name (First, Middle, L James G. Chag	ŕ					2. Date of Deat Month		3. Time of Death 7:10P
	/Medi Examir		4a. Facility Name (If not institution, g				4b. City, Town, o	or Location of Death		4c. County of	
	LAdilli		Gilchrist Hos	pice			Towso	n		Ba	ltimore
	Funeral		Social Security Number 6.		je (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)) 9	Birthplace (State or Foreign Country)
	Director		220-03-1966	1 □ X M 2 □ F	91	Yrs.	Months Days	nours will.	1-30-1	918	PA
	and w]	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation				10d. Inside City Limits
	Aaryk f sho	5			,						Y Yes 2 No
	n the Maryland r 28a-f show notified at	Director	MD 10e. Street and Number		Ba.	ltim	ore Cit	У	1	0g. Citizen of Wha	at Country?
	23a or	ā	725 S. Oldha	m Street			2122	4		USA	it Godiniy.
	death with the Maryland rms 23a or 28a-f show r must be notified at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	_1	Hispanic Origin? (Span, Mexican, Puerto			American Indian,
٥	or ite	교	1 ☐ Never Married 2 Married	Armed Forces?	No		lf Yes, specify Cub 1 □Yes 2『¥No		o Rican, etc.)		White, etc.
2-003p	hours after tural", or ite	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	IIWV		ILIYes 21-No	Specify:		Specify:	White
	72 Inai	Completed	15. Decedent's (Specify only highest g	Education rade completed)		16a. Dece (Give	dent's Usual Occup kind of work done	oation during most of worl d)	king I	16b. Kind of Busin	ess/Industry
N	E 9. E	g	Elementary/Secondary (0-12)	College (1-4or 5	5+)						1
A	Hyg H		12 17. Father's Name (First, Middle, Las	st)		i	Steel W			Crown C Maiden Surname)	ork & Seal
/land		o Be	Gus James Ch	•					Kostan	*	
<u></u>	should be and Menta is marked aumatic ev	မ	19a. Informant's Name/Relationship			19b. Mailir	na Address (Street	and Number or Ru			ate Zin Code)
Š	od 2 tiff 8 27 is r tra		Angela Chaget					ham St.,			
ē,	s 1 ar		20a. Method of Disposition				sition (Name of natory or other place			20c. Location - Cit	
airimor	Pages nent of int: If its iry or o		1 ☐ MSurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec					ery 7-29	2-09	Baltimo	re MD
<u>=</u>	permit. Pages : Department of b Important: If ite any Injury or of		21. Signature of Funeral Service kic		104.12	22	. Name and Addre	ess of Facility Pra	Alev-A	shton F	uneral Home
۵	e e e e		DUNGER			$ _{\mathbf{p}_{i}}$	A. 2134	Willow	Spring	Road.	21222
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that caused	the death.						Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	Fal	20 0	W.Y	hodi	ontoid	FrAC	ture	Onset and Death
New York	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):				763	
	LAAIIIIIGI	<u>.</u>	Sequentially list conditions,	b						FX	
	rted nsit	nine	Sequentially list conditions, if any, reading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a sunsequer	iec of):			1 -	25	
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequer	nce of):		2000		, by	
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8	tificat ig phy as the	edi		u.				THE WAY	Milia		
5	h cer endin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1 = ·		1.3	23d. Date o	f delivery
•	deat he att	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnand Other (specify)	x/ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\		Month	Day Year
ב ב	at the I by th	ېل کې	9 Unknown								
<u>,</u>	res th signer be de	þ	Part II. Other significant conditions	contributing to death but	ut not resultir	ng in the ur	oderlying cause giv	ren in Part I.	-		ite to the cause of death?
GIGS,	requi	Completed	C D:	review 1	14 (_	01110	- CONTRACT	1 ∐ Y∈	es 2. 1 No 3[Probably 4 Unknown
ַ בַ	e law has b e 2 si	lg l	Salure						24a. Was a autops	sv l prio	re autopsy findings available r to completion of cause of
ָ ק	icate icate i, pag								perform 1 □ Yes 2		th? Yes 2 □ No
-	siciar certif	Be	25. Was case referred to medical examiner?	Hospital:			Oth	ori	th (Check only on		// 1.0
5 1	Phys rthis raf di	<u>۲</u>	1 ¥Yes 2 No 27. Manner of Death	1 Inpatie	ent 2 ER	l/Outpatien Bb. Time of		4 LJ Nursing H		ence 6 Other of the formal of	
5 :	th. : Afte	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y, Year)	Injury_	Worl	k? Yes 2 X No	Sall our		and housed
	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not	be 290 Place of Init					28f. Location (St	reet and Number of	or Rural Route Number,
5 .	salor safte at Dir	Sert	4 ☐ Homicide determine	building, etc					725 S.OL	d ham St.	Balto md
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the teacher.		29a. Certifier 1 Certifying F	hysician: To the best of	of my knowle	edge, death	occurred at the ti	me, date and place	, and due to the c	ause(s) and mann	er as stated.
	tne H nin 24 the F nplete	ledical	Une)	and manner sta	ated.	1 and/or in	vestigation, in my c	opinion, death occu	rred at the time, d	ate and place, and	ue to the cause(s)
1	con diff	Σ	29b. Signature and title of certifier	1-0		1	29c. Licens			9d. Date signed (A	
	11		Il. forther	7 Kily	1 va)	1/2	2 202	_	Julya	6,0009
	41		30. Name and address of person who	completed cause of de	1	Ba) (Type, I	Print)	les C+	Balt.	nad ?	21204
	Sta	te	31. Date filed (Month, Day, Year)		@70 ar's Signature		-	-, -,	TRECTO	1000	
	Registr		000c Q Q 1111	D	A A	an also					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPt1,25 per man 8893 07/30/09dhb, 19a per inf.
Reg. No. | | 1 - For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year DORSEY **Physician** 10:16 AM DENNIS 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Months Days Oct.16.1950 Maryland Director 214-56-8002 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I've Modes (Examina in ust be notified at Yes 2□No Directo Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 203 Bridgeview 21225 Funeral Road USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces be filed within 72 hours after on tal Hygiene. ed other than "natural", or iter 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyBlack \$ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping/Receiving Clerk Art Litho Company 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be.
Department of Health and Mental Important if Imm 27 is more any injury or other. Norsie Davis William Dorsey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) **Evelyn Stukes**Evelyn Stokes/ Compa Companion 203 Bridgeview Road Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ② Cremation 3 ☐ Removal from State Greenmount Cemetery 6/26/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Functal Service Licensee 5240 Reisterstown Rd. Baltimore, MD 21215 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. REFRACTORY SEPTIC SHOCK SECONDARY TO CELLULING Immediate Cause (Final 24hours **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): FIDNEY INJURY. Secondary to 24hours Examiner ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): APROVED BY MEDICE EXAMINER Sepsis Examine The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ś RHABDOMYOLYSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nerformed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No or Attending Physician: 26. Place of Death (Check only one) funeral director. 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JUNE 23 2009 DOYIJE IHEA C.WARA RES 000 MARYLAND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

21225

OYIJE IHEAGUARA, 3001 SOUTH HANOVER STREET, BALTIMORE,

		1 - For State Registrar	State of Maryla	nd / Depa		t of H	ealth ar	nd Mei	ntal Hygie	_	0.9	2438
Physic /Med	ical	Decedent's Name (First, Middle, Last) Margaret M. Doh 4a. Facility Name (If not institution, give s			4b City	Town or	Location of		Date of Death Month July 16		Year Year	3. Time of Death 9:30 AMM
Exami Funeral Director	F	Laney's Assisted 5. Social Security Number 6. Sex	l Living	s. <i>last birthday)</i> O Yrs.	,	seda			Date of Birth (Month, Day, Y ar 25,	Ba1	timore	lace (Stete or Foreig
9		Usual Residence of Decedent 10a. State 10b. County MD	10c. C	City, Town or Lo							1	0d. Inside City Limits
eth with the 23a or 28	Funeral Director	10e. Street and Number 3432 Chesterfield			10f. Zip		21213			USA		
is 1 and 2 should be filled within 72 hours after deeth with the Maryland of Heeth and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23s or 28e-f show other traumatic event, its Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Deced It Yes, spec 1 ☐ Yes		spanic Origin , Mexican, Specify:	in? (Specifi Puerto Ric	y Yes or No- an, etc.)	Bla	ice - Americ ack, White, ify: Whi	etc.
within 72 ho ane. then "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		16a. Deced (Give life.					16	3b. Kind of E		dustry
utd be filed Mental Hygid Irked other Itlc event, II	To Be Co	17. Father's Name (First, Middle, Last)			iala_e	entry		s Name (F	First, Middle, Ma	aiden Suma	roll me)	
and and le m		19a. Informant's Name/Relationship (Ty) David Dohler/son			2 Che	ester			oute Number, o	imore	, MD	21213
Page nent c ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Spirit License	emoval from State	cemetery, crer	matory or o	ther place				c. Location		
permit. Deperti		23a. Part1. Enter the disease, or complishock, or heer tailure. List only on	ations that caused the de	Ba	1time	re,	MD 2	1201_	5 W. Ba		re St	Approximate Interval Between
Physician /Medical Examiner	ı	Immediate Cabse (Final disease or condition resulting in death)	Due to (or as a conse		3NC	EL						Onset and Death
ate be executed hysiclen and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse									
To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ac. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tel death 3	Ectopic pr						ate ot delive	ery Day Year
w requires that been signed be should be deta	þ	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	nderlying c	ause give	n in Part I.					ne cause of death?
n: The law ificete hes b	e Completed	25. Was case referred to medical					Bi		24a. Was an autopsy performe	∌d? ⊿No	Were auto prior to co death? 1 Yes	psy findings availabl mpletion of cause of 2□ No
ysicla s cert direct	To B	avaminar?	ospital:	☐ ER/Outpatier	nt 3□ DC	Othe			5 Residen		ther (Specif	(v)
Attending Physician: The lavar death. ector: After this certificate hes by the funeral director, page 2 to	Certification: T	27. Manner of Death 1 Patural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 2	8c. Injury Work		280	d. Describe how			,,
To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t		4 Homicide determined	28e. Place of Injury - At building, etc. (Special ician: To the best of my k	cify)			n statu ner t		City or Town,	State)		al Route Number,
HOS 724 h	Medical	(Check only 2 Medical Examin	er: On the basis of examinand manner stated.	nation and/or in	vestigation	, in my op	inion, death	occurred	at the time, dat	e and place	, and due to	the cause(s)
To th To th comp	Me	29b. Signature and title of certifier	Mo			DSS	306	5			ed (Month,	Pay, Year) 2009
St	ate	30. Name and address of person who co	npleted cause of death (It A2. Registrar's Sig	Suite.	Print)	Car	more	m	2123)	-		
Regist		111 2 9 2009	Russe &	bar	Les .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 2 State of Maryland / Department of Leatth and Mental Laygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 07 2009 21:48 PM 10 Charlotte Louise Edwards /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bel Air, Maryland

If Under 1 Year If Under 24 Hrs. Min. Months Days Hours Min. 03/11/1947 Harford Upper Chesapeake Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 🗙 F Maryland Director 62 213-48-3589 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State ral", or items 23a or 28a-f shov 1 ☐Yes 2 No MD Baltimore Baldwin Director 10e. Street and Number **Fork** 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21013 13575 Ford Road - P.O. Box 94 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify: Specify: White à 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaking Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Louise Lechert Charles Lewis Glodek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1518 Lake Norwood Way - Sandy Springs, MD 20860 Frank W. Glodek (brother) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ŏ 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 07/17/2009 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) signature of Funeral Service (icensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the deal No. not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cirrhosis Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PAFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 5 Other (specify) o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform certificate 1 ∐ Yes Vital or Attending Physician: 25. Was case referred to medical examiner?
1 X Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA ō 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral D 29a. Certifie tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medic | Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check one) and manner stated 29d. Date signed Month, Day, Year, 29b. Sign

State Registrar 501 South Union

9 9 2000

31. Date filed (Month, Day,

ò

LE HOVIEDEGRACE, MO

21078 Houtan Sareh, MD

to completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HIER

			For _ State	State of Ma	aryland /	•			Mental Hy		000	01000
			Registrar 1. Decedent's Name (First, Middle, La	of)		Cer	tificate of I	Death	2. Date of De	Reg. No.	000	3. Time of Death
н	Physician FRED-RICK					FO	VIV.		Month	Day	Year 200	70 1000
	/Medic Examin		As Facility Name of the Control of t					r Location of Death	1004	2 8 4c. Coun	ty of Death	11
لمرسب	Examin	ë	JOHNS HOPKINS								N	/A
	Funeral		5. Social Security Number 6. 5	Sex 7. Age	e (In yrs. last	birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Date) April	th	9. Birth	nplace (State or Foreign
м	Director		210-34-6242	M 2□F	71	Yrs.	Worting Bayo	TIOGIS WIII.	April 1	8,1938		MD
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
	Maryl f sho	호	MD Anne Art	ınde1		Seve	rna Park					1 □Yes 🎢 No
	the 28a	Director	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·		10f. Zip Code			10g. Citizen o	f What Cou	untry?
	3a or		637 Shore Road				21146			U.S.A.		
	deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No)- 14. R	ace - Amer lack, White,	ican Indian,
36	be filed within 72 hours after death with the Maryland tial Hygiene. do other than "natural", or items 23a or 28a-f show event, the Modicel Ever internust be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 📉 N If Yes, Give Year or Dates;	lo		I∐Yes 2⊠No	Specify:	- , , , , , , , , ,		eify: Wh	
21215-0036	2 hour		15. Decedent's E	ducation	1	6a. Deced	dent's Usual Occup	ation		16b. Kind of	Business/Ir	ndustry
215	within 7% iene. **Than "nan" in in in in in in in in in in in in in	Completed	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5	+)	(Give life, L	kind of work done of NOT use retired	during most of wor d)	king			
2	filed withir Hygiene. xther than ent, ire	Con	12			Busin	ess Owne			Heavy		pment
Maryland	ould be filk Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Last William Dorsey Et					18. Mother's Nam	ne <i>(First, Middle</i> E . Fenni	•	ıme)	
3	d 2 should be th and Mental 7 is marked of traumatic ev	은	19a. Informant's Name/Relationship		Τ.	10h Mailin	ng Address (Street				n State 7	in Cada)
Ma	2 is		Mrs Sandra A. Ery		1		shore Roa			=		ip Code)
d)	es 1 and 2 of Health of Item 27 i		20a. Method of Disposition				sition (Name of natory or other place		Date 30,	20c. Location		Town, State
altimore,	permit. Pages 1 Department of I Important: If ite any Injury or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1 .		Cremator	1 27	Š09°'	Glen B	urnie	, MD
alti	permit. Departr Imports any Inju		21. Signature of Funeral Service Lice	nsee		22	. Name and Addre	ss of Facility \$17				
<u>m</u>	90 E # 9	1 1	Moi35 Dervices PA 1 2nd Ave. SW Glen Burnie, M									
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Betw.									Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition a. Sepsis: 3 days								0 1	
	Examiner		Due to (or as a consequence of):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a consequen	ce of):		10				
	cuted nd ransit	Examiner	causé. Enter Underlying Course (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
, 0	ficate be executed g physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):									
68760,	cate b physic the b	d										
		/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy	/				004.5	الماد عد مدد	
Вох	death certif e attending ed for use as	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	ath 3	Ectopic pregnanc Other (specify)	у			23d. Date of delivery Month Day Year	
0	the sy th	Physician/M	1 □ Yes 2 □ No 9 □ Unknown									
о, С	w requires that the s been signed by th should be detache	by P	Part II. Other significant conditions	contributing to death bu	ıt not resultin	ng in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
ğ	equire en siç ould b		end-stage rena	l diseas	e, tr	ach	eostom	4,	1 🗆	Yes 2 No	3☐ Pro	obably 4 Unknown
ecc	as k	plet	history of end	ocarditis	with	mit	ral value		24a. Was		. Were aut	topsy findings available completion of cause of
	Th cate pag	Completed	replacement x Z.	sternotor	nu iv	tect	non			ormed? 2 No	death? 1 □Yes	2 X No
Vita	ding Physician: Th n. After this certificate funeral director, pag	Be	25. as case referred to medical examiner?	Hamital	7		Tou.	26. Place of Dea	th (Check only	one)		
of	Phys this	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		Outpatier	nt 3 DOA Oth	4 Li Nursing H	ome 5 Res	how injury occi		cify)
on	Attending F r death. sctor: After by the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		Injury	Worl	k? Yes 2 □ No	260. Describe	now injury occi	JileQ	
Division	Attend r death ector: by the f	ifica	3 Suicide 6 Could not be determined	e 28e. Place of Inju	iry - At home	, farm, stre	eet, factory, office				nber or Ru	ral Route Number,
Ö	tal or	Certification:	4 Homicide	building, etc	:. (Specify)				City or ro	wn, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		hysician: To the best of miner: On the basis of and manner sta	examination							
	To the within To the complete	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date sigi	ned (Month	n, Day, Year)
			5 MD. F	hD		V	RE:	$s-\phi\phi\phi$		JULY	28	2009
			30. Name and address of person who		eath (Item 23	Ba) (Type,		, , ,		- (21224
			EMILY SPEC	ELMOU 32 Registra	MT ar's Signature	Ph.	D 494	6 EASTER	2N AVER	UE BAL	Timor	E, MS
	Sta Registr		JUL 3 0 20	19 Deren	ar's Signature	pa	ike					

			Please Type or Print in					_		
			For State Of Mary 96		Certificate of I			g. No. 2 () () (24391	
	Physicia	an	1. Decedent's Name (First, Middle, Last) Robert Charles Franke				Date of Death Month	Day Year	3. Time of Death 9:00 A M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death		
p.	F		Lookabout Manor 5. Social Security Number 6. Sex 7. Age (In y	yrs. last birth		stminste:	8. Date of Birth (Month, Day,	Carro	irthplace (State or Foreign	
	Funeral Director		213-36-4764 ¹XI M 2□F 7	2 Yr	Months Davs	Hours Min.	(Month, Day, 4-22-19		ryland	
	ryland how			City, Town o					10d. Inside City Limits	
the Ma	the Ma 28a-f s	Director	MD 10e. Street and Number		Baltimo	ore City		g. Citizen of What C	Yes 2 No Country?	
	th with	al Di	729 S. Linwood Ave.			21224		USA	·	
_	iter dear	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☒ Yes 2 □ No	ı U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
5-0036	hin 72 hours after death with the Maryland a. "natural", or items 23a or 28a-f show Medical Examinant by Indiffed at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □Yes 2√∑No			Specify: W		
က်	na Ina	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. D	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	ation during most of working)	ng 1	6b. Kind of Business	s/Industry	
. 4	wij Hen	Com	12 7		Attorney	40 Mathada Nasa	(First Middle M	State		
lano	be de la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle, Last) Frederick C. Franke		Mary (dle, Maiden Surname) sight		
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Shirley L. Franke-wife		Mailing Address (Street					
	s 1 and 2 f Health item 27 other tr	L.			Disposition (Name of crematory or other place			0c. Location - City o		
altimore,	permit. Pages Department of Important: If it any Injury or o		INTERNAL Z I ICREMANON 3 LI BEMOVALITORI SIALE I		nore Cem.	7-30		Baltimor		
Ball	permit Depart Import any In		21. Signature of Funeral Service Licensee	4					Home, P.A. MD 21157	
			23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	eath. Do no	ot enter the mode of dyir	ng, such as cardiac o			Approximate Interval Between Onset and Death	
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a constitution)	Inx	demen	tia			Onset and Death	
	Examiner	L								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	sequence of):					
oc,	eath certificate be executed attending physician and for use as the burial-transit	_	resulting in death) Last Due to (or as a cons	sequence of):					
	tificate g physi as the b	Physician/Medica	d			01070	~			
ROX	death certificate e attending phys ed for use as the	lan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	Fetal death	3 ☐ Ectopic pregnanc	Эу		23d. Date of d	lelivery Day Year	
7. O	t the de by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	of death	5 ☐ Other (specify) _					
JS, F	w requires that the di been signed by the should be detached		Part II. Other significant conditions contributing to death but not	resulting in t	he underlying cause giv	en in Part I.			to the cause of death? Probably 4 D Unknown	
Kecoras,	law requ as been 2 should	Completed by					24a. Was an	24b. Were	autopsy findings available	
	The ate h page	Com					autopsy perform 1 □ Yes 2	prior to death? DNo 1 1 Ye		
VITAL	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2		patient 3 DOA Oth	26. Place of Death		nce 6 Other (Sp	Dewit I'm	
n or	ing Ph	ion: T	27. Manuer of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year	28b. Tir	me of 28c. Injui	ry at rk?	28d. Describe how		Citan	
Vision	or Attending after death. Director: After in by the funer	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Sp	At home, farn]Yes 2□No	28f. Location (Str. City or Town,	eet and Number or	Rural Route Number,	
בֿ	pital or urs afte eral Dir illed in		29a. Certifier 1 Certifying Physician: To the best of my		don'th conveyed at the till	ima data and class			an atatad	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated.							
	Noth With To t	Σ	29b. Signature and title of certifier		29c. Licens	se number	29	d. Date signed (Mo		
,			30. Name and address of person who completed cause of death ((Item 23a) (T	ype, Print)	1	111	VT-V8	5-2009	
į	Ų V Sta	to	31. Date filed (Month, Day, Year) 32. Renstrars Si	e t	Vestm	inster	Nd	2115	> (
	Registr		31. Date filed (Month, Day, Year) 32. Applistrars Si	1.	parke					

			1 _ State	State of Marylan		rtment of F tificate of I			0001	01000	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	incate of t	Jeani	2. Date of Deat		3. Time of Death	
	Physici: /Medic		Zettie I	H. Felton				July 26	, 2009 Year	16:44 M	
	Examin		4a. Facility Name (If not institution, give stree Southern Maryland H	· ·		4b. City, Town, or Clinton	Location of Death		4c. County of Dea		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bi	rtholace (State or Foreign	
	Director		579-50-1737	282 89	Yrs.	WOTHIS Days	Tiours Will.	March 7	, 1920 Sou	th Carolina	
	how		10a. State 10b. County		y, Town or Loc					10d. Inside City Limits	
	he Ma	Director	Maryland Prince Geo	rge's	CII	Inton			0g. Citizen of What C	1 HYes 2 No	
	23a or 3	ral Dir	100. Street and Number 10005 Derrick Plac	.e		10f. Zip Code	20735		U.S.A.	ountry r	
036	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. The man and Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3XXWidowed 4 Divorced	Was Decedent Ever in U.s Armed Forces? 1		Vas Decedent of H iYes, specify Cuba □Yes 2 Kan	ispanic Origin? (S in, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Whi Specify:		
15-0	'natur	ieted	15. Decedent's Educati (Specify only highest grade co	on om <i>pleted)</i>	16a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of work	king	16b. Kind of Business	/Industry	
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pu	be filed Ital Hyg Id othe event,	Be	17. Father's Name (First, Middle, Last)	Unwis				ne (First, Middle, I Lessie S	Maiden Surname)		
ıryla	should nd Men marke matic	ဥ	Joseph Z. 19a. Informant's Name/Relationship (Type.		19h Mailin	a Address (Street				Zip Code)	
, Ma	and 2 s lealth ar m 27 is her trau	2 2	Ardusters N. Felton,	Jr. (Son)	1				r, City or Town, State, Maryland		
altimore, Maryland	Pages 1 tment of H tant: If ite jury or otl		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	Ci	emetery, crem vland l	sition (Name of patory or other place Nat. Park	e) ; K Augus	t 1, 200	20c. Location - City o 19 Laurel, Funeral I	Maryland	
Ba	Departing Departing Important In any In conce.	g y	21. Signature of Funeral Service Licensee	M0977	4:	Name and Address 217 9th S	Street, N.	W. Washi	ngton, D.	20011	
			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of						rest,	Approximate Interval Between Onset and Death	
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	uence of):	940/7	ailur	0			
	Examiner		Sequentially list conditions, b. –	Hype	nat	remia					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as # nonsequ	ienda of):						
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68760,	ficate b physic s the bi	edical	d								
Box	eath certifi attending for use as		Zob. Was decedern pregnam	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	W		23d. Date of d	,	
о В	at the dear by the att tached for	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4 Pregnant at time of d		Other (specify)	y		Month	Day Year	
۰, ۳,	res that t signed by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						obacco use contribute to the cause of death?		
ords	w require been sig should by				-			1 □ Y€	es 2 X 2No 3∐ I	Probably 4 Unknown	
Division of Vital Records,	has e 2	Completed						24a. Was a autops perform	sy prior to med? death?		
/ta	sician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?		900-	Tau		1 □Yes th (Check only on		S ZEANO	
of	this al	ဂ္	1 ☐ Yes 2 ☐ Hos	ortal: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ZR/Outpatien 28b. Time of	t 3 DOA Oth-	4 LI Nursing H		ence 6 Other (Sp ow injury occurred	ecify)	
ion	Attending F death. ctor: After y the funera	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		⟨? Yes 2□No				
Divis	tal or Atters as after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						treet and Number or F n, State)	Rural Route Number,	
	Io the Hospital or within 24 hours after To the Funeral Directory Completely filled in the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Published Total Original Publi	Medical (an: To the best of my known to the basis of examination and manner stated.							
	vithir To th	Me	29b. Signature and title of confiner	, //		29c. Licens	-		29d. Date signed (Mor		
		}	30. Name and address of person who comp	leted cause of death (Item	23a) (Type 5		3209		7-26-00	7	
			Wenderl Pierso	7503 Sur	ratts	Road Cli	nton, Ma	ryland	20735		
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 9 2009	2. Registrar's Signat	ture	al de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Haze1 Marie Gartside luc /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE BALTIMORE GLEN BY WAGTONGTON MEDICAL CENTER unidel IRNIE If Under 1 Year 8. Date of Birth (Month, Day, July 8, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 68 377-38-5227 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Madical Examirar must be rollified at 1 ☐ Yes 2 X No Director MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 722 Rosewood Road 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is manked other than "natural", or i any Injury or other traumatic event If Yes, Give Year or Dates 1 ☐Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Westinghouse Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Canfield Hyacinth Brown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Thomas E. Gartside/Husband 722 Rosewood Road Severn, MD 21144 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 31, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Atlantic Crematory 4 □ Donation 5 □ Other (Specify) 2009 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (Unas a consequence of) Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Year 5 Other (specify) signed by the a 1 □Yes 2 □No Ö 9 Unknown 9 Unknown Δ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been Were autopsy findings available prior to completion of cause of death? page 2 s certificate has autopsy performed 1 □ Yes 2 🗗 1 ☐Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of e Hospital or Attending P 124 hours after death.
e Funeral Director: After t letely filled in by the funera Division 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

within 2

29b. Signature and title of certifier

Glen Burnie

and manner stated.

Hornital

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4:35a M July 29 2009 Donna L. Godsey 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gilchrist Hospice Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) Year) Months Days 1 ☐ M 2 🖫 F 59 213-52-0519 Oct.2,1949 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD Baltimore Rosedale 1 ☐Yes 27 No 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 2 King Henry Circle 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Professional Elementary/Secondary (0-12) College (1-4or 5+) Order Filler Beauty Supply 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melford Loane Jane Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Godsey /husband 2 King Henry Circle Baltimore MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Surial 2 □ Cremation 3 □ Removal from State Holly Hill Cemetery 7/31/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 ions that caused/the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas (o. conshock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Year Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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s 23a or 28a-f show

d other than "natural", or items event, the Medical Examiner management

and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n amy injury or other traur

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Baltimore, Maryland 21215-0036

Director

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sician and burial-trans attending physician the esn Į. signed by the a icate has been significate page 2 should b

certificate After this To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Division of Vital Records,

Sequentially list conditions Examine day, leading to in media cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) WUSD/4 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Dath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1/1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIES

Baltimore, Maryland 21215-0036

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Physicia	an	Nalini Natwarlal Gandhi		Month	Day Year	
/Medic		4a. Facility Name (If not institution, give street and number)	4h. City Town, or Location of Death	July 23		
Examin	er	Holy Cross Hospital	*			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		
Director		436-92-7627 1□ M 2\XF 69 Yrs.	Months Days Hours Min.	05-24-19	40	
pu ,		Usual Residence of Decedent	- 41			10d Incido City Limite
arylaı shov	_	10a. State 10b. County 10c. City, Town or Loc				
Ba-f	Director	MD Montgomery			Citizen of Minet Co.	
with ti	٦	10e. Street and Number		Tog		
filed within 72 hours after death with the Maryland Hygiene. Hygiene, within "natural", or Items 23a or 28a-f show ent, the Interfeed Examination noithwith	Funeral	14625 Stonewall Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13. W		cify Yes or No-		
ter de	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No	Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)		
urs af	þ	If Yes, Give 1 3 Widowed 4 Divorced Year or Dates:	□Yes 2X No Specify:		Specify: Asia	an Indian
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ges 1 If ite or ot		I Buriai 2 Li Cremation 3 Li Removal from State	i		c. Location - City or i	own, State
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventinal must be notified at once.		21. Significant of Funeral Service Licenses 22.	Name and Address of Facility Donaldson Funeral 1411 Annapolis Roa	Home & C ad Odento	rematory, n, Maryla	P.A. nd 21113
1150		23. Part . Enter the disease, or complications that a sed the death. Do not ente shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arrest	,	Approximate Interval Between
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death e atte d for	icia	in the past 12 months? 1	Other (specify)		Month	Day Year
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hysic nis ce	70 E	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient	t 3 DOA Other: 4 Nursing Hor	me 5 Residence	ce 6 ☐ Other (Spec	cify)
ng Pi	ü	27, Manner of Death 1 Matural 5 □ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c, Injury at Work?	28d. Describe how	injury occurred	
endin sath. or: A	satic	2 Accident investigation	M 1 □Yes 2 □No			
or Att after de Directs in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streething building, etc. (Specify)	et, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
ital curs al						
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical					
To the withing to the complex	Ž	29b. Signature and title of certifier	29c. License number	290	l. Date signed (Month	, Day, Year)
					July 23,	2009
200				ring, Man	ryland 209	10
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 2. Apart				

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chael Grum		State of Ma 1- For State Registrar	ryland / Departn <i>Certifi</i>	ment of He icate of De		Mental Hy	giene Reg	. No. 20	09 2439
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edical Exami	ner	Michael A. Grum 4a. Facility Name (if not institution, give street a	1 1 2	145.0		anting of Doubh	Month I July 26, 200	9 4c. County of Dea	2032 hrs
		MD 152 and I-695	na number)		ındalk	cation of Death		Baltimore Co	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	pirthday) If	Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. E	
Director		175-38-6151 1 MM 2 Usual Residence of Decedent	F 60	Yrs.	onths Days	Hours Min.	8-2-19	948 For	Country)PA
any		10a. State 10b. County	10c. City, Tov	wn or Location					10d. Inside City Limits
ith the Maryland 23a or 28a-f show any notified at once.	٦	MD Baltimore	Dund	dalk					1 XYes 2 No
faryla 28a-f	ect	10e. Street and Number		10f	. Zip Code		10g	g. Citizen of What Co	ountry?
the Na or	盲	2810 Moorgate Roa	đ		21222			USA	
215-0036 be filed within 72 hours after death with the Maryland mal Hygienen man Head other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 12. Wa	s Decedent Ever in U.S. ned Forces?			inic Origin? (Sp. Mexican, Puerto I		14. Race - Am- White, etc.	erican Indian, Black,
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ore, MD ss I and 2 sho of Health and ff item 27 is		<u>Leah Strait - Wif</u> 20a. Method of Disposition		2810 Note of Disposition	Name of ceme	te Road	d, Dunc	dalk, MD 20c. Location - City	21222 or Town, State
Baltimore, MD 2 bernit. Pages I and 2 shou Department of Health and N Importantt: If item 27 is n injury or other traumatic		1 Burial 2 Cremation 3 Remo	Val II Olii State	natory or other p	lace)		1		
Itim it. Pa irtmen ortant		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licersee	Bayı	view Ci	and Address of	f Facility	29-09	Baltimo	
Baltimore, MC permit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traum		1111	7			Bra	adley-	Ashton F	uneral Home
Physician		23a. Part I. Enter the disease, or complications	that caused the death. Do	not enter the m	ode of dying, su	ich as cardiac oi	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
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68760, certificate be nding physic	an/N	23b. Was decedent pregnant in the past 12 months?	Live birth	2 Fetal d	eath 3	Ectopic pregna	ncy	Month	Day Year
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E 72 7 5	Medical	one) 2 Medical Examiner: On the	ne best of my knowledge, one best of examination and/o	death occurred a or investigation,	at the time, date in my opinion, c	e and place, and death occurred a	due to the cause t the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier	nner stated.		29c. License			29d. Date signed (i	
		his his wo			O.C.M	.E.		July 27, 2009	
		30. Name and address of person who complete	d cause of death (Item 23	a)	L				
51		· · · · · · · · · · · · · · · · · · ·	Examiner 111 Pe		Baltimore, M	ID 21201			
	tate		32. Registrar's Signature						
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Kimball Greer 09-05857

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NK UNK	State of Maryland / Department o 1- For State Certificate o		ygiene Reg. No.	09 2139
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last) Kimball R. Greer		2. Date of Death Month Day Year July 27, 2009	3. Time of Death 0145 hrs
Funeral	4a. Facility Name (if not institution, give street and number) Union Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Baltimore If Under 1 Year If Under 24Hrs.	. 8. Date of Birth(MM/DD/YYYY) 9.	Birthplace (State or
Director	214 86 7325 1X M 2 F 46 Yrs	Months Days Hours Min.		reign Country) MD
Maryland 28a-f show any d at once ector	10a. State 10b. County 10c. City, Town or Loca MD n/a Baltim			10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f she notified at once	10e. Street and Number 5500 Ritter Avenue	10f. Zip Code 21206	10g. Citizen of What C	Country?
"natural", or items Examiner must be ted by Funers	1 Never Married 2 X Married Armed Forces? If N 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Deceder	as Decedent of Hispanic Origin? (Spress, specify Cuban, Mexican, Puerto Yes 2 X No specify: nt's Usual Occupation (Give kind of votes of working life, DO NOT use reti	Rican, etc.) White, etc specify black work done 16b. Kind of Busine	ack
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu injury or other traumatic event, the Medical Exan To Be Completed	12th cook 17. Father's Name (First, Middle, Last) Frederick Greer		Restaus (First, Middle, Maiden Surname) Radcliffe	rants
MD 212 ad 2 should be lith and Menta n 27 is mark aumafic even	Joanna Padaliffa (aunt) 550	O Dittor Aug	Rural Route Number, City or Town, S Balto, Md. 2120	0.6
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Obnation 5 Other Specify: 20b. Place of Disposition crematory or or Green Methods and State Green Methods are supported by the specific or or or or or or or or or or or or or	ition (Name of cemetery, her place) Ju ount Crematory	Date 200. Location - City 31, 2009 Ba	y or Town, State alto, Md.
Balt Balt Balt Balt Balt Balt Balt Balt	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	alvin B. Scrug	gs Funeral Hor	ne 21213 **pproximate Interval
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cocaine and narcotic Due to (or as a consequence of):	(morphine) into	oxication	Between Onset and Death
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). Box 6876C the death certificate! by the attending phys the dor use as the by Physician/Me	past 12 months?	etal death 3 Ectopic pregna ther (Specify)	23d. Date of deli Month	very Day Year
cords, P.O. E law requires that the d has been signed by the 22 should be detached npleted by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		
Vital Records, ysician: The law require his certificate has been significate, page 2 should be o Be Completed	25. Was case referred to medical	26.Place of Death (Check	performed? deat	h?
ing Ph After t funeral	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending Fd 7/27/09 Fd 1:1	t 3 DOA Other Nursin		other:
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the funeedical Certification:	3 Suicide 6 X Could not be determined (Specify) Suicide 1 Suicide 28e. Place of Injury - At home, farm, street found on stook	op of rowhouse	28f. Location (Street and Number of Town, State) 1618 N. Baltimore, MD	
To the Hos within 24 h To the Fun completely	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b. Signature and title of certifier	ttion, in my opinion, death occurred a	at the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and date and place, and due to the time, date and the time, date an	to the cause(s)
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	July 28, 2009	
State	Donna M. Vincenti, MD Assistant Medical Examiner 11	1 Penn Street, Baltimore, M	ID 21201	
Registrar DHMH 17 Rev 1/2001	1111 00 0000 6	AL		

DHMH 17 Rev 1/2001 OCME 2006

Please	Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
	State of Maryland / Department of H	ealth and Mental Hygiene

		For State Registrar		State of I	vlarylan	-	ertment of F <i>rtificate of</i>				giene Reg. No. 🤈	2000	21.21	a o
		Decedent's Name (F.	First, Middle, Last,)						2. Date of Dea	ath	Year	3. Time of Dea	ath
Physicia /Medica	_	Joseph Ed	dward Ga	rity						July 2	23, 20)09 Year	3:50 AM	М
Examine	- 1	4a. Facility Name (If no			,		4b. City, Town, o		n of Death		4c. C	ounty of Death	1	
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Funeral Director		577 - 56 - 83	147	M 2□F	66		Months Days	Hours		Aug 25	, Year) 194	2 Wash	nington D)C
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72 hours after death with the Maryland 'natural'', or items 23a or 28a-f show oten Evzri in the to the death	Funeral Director	11. Marital Status		12. Was Decede	nt Ever in U.	.S. 13. V	Vas Decedent of F f Yes, specify Cub		Origin? (Sp	ecify Yes or No		. Race - Amer		
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hours	d by	3 ☐ Widowed 4 ☐		Year or Date	s:			, atlan			أحطحت	of Business/li	a di raturi	
in 72	plete	(Specify o	. Decedent's Edu- only highest grade	e completed)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during mo d)	ost of work	ing	TOD. KING	or business/ii	U	ınk
filed within Hygiene. rther than "	Completed	Elementary/Secondar	ry (0-12)	College (1-4d	or 5+)	1	ncy buye							
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f Heal f Heal tem 2 other		20a. Method of Disposit		-y/ 3pous			sition (Name of natory or other place			Date		tion - City or T		
permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "rany Injury or other traumatic event, The Mode.		1 ☐ Burial 2 ☐ Ci 4 ☑ Donation 5 ☐		Removal from Sta	te C	cemetery, cren	natory or other plac	ce) ;						
rmit. spartn porta y Inju		21. Signature of Funera		Jack / DA	/ recto	r 22	. Name and Addre	ss of Fac	ility Roard		12 n 1	timoro	Stroot	
99 E 29		JUVV	VVIVI	11.80		Ba	ltimore.	MD	2120	1		-	prieer	
		23a. Part 1. Enter the d shark, or heart fa	ailure. List only or	ne cause on each	line.				as cardiac	or respiratory ar	rest,		Approximate Interval Betweer Onset and Deat	n
Physician /Medical		Immediate Cause (Fina disease or condition resulting in death)	al .	1			SPATH	7						
Examiner		,		Due to (or	as a conseq	uence of):								
	je	Sequentially list condition if any, leading to immediate. Enter University Cause (Disease or injurial cause (Disease or injurial cause)	ons, diate	Due to (or	as a conseq	uence of):								
ficate be executed physician and s the burial-transit	Examiner	that initiated events		.										
oe exe zian al urial-t	Ë	resulting in death) Last		Due to (or	as a conseq	uence of):								
eath certificate be executed attending physician and for use as the burial-transit	edical			l										
certiff nding use as	√Me	IF FEMALE: 23b. Was decedent pre	anant 2	3c. If yes, outcor	ne of pregna	ancy		-			23	d. Date of deli	verv	
death e atte	Physician/M	in the past 12 mor	nths?	1 ☐ Live birt 4 ☐ Pregnar	t at time of o		Ectopic pregnand Other (specify) _	;y				Month	Day Year	•
at the	hys	9 🗆 Unknown		9 ∐ Unknow	n 									
	by	Part II. Other significan	nt conditions cor	0		0	, 0	en in Par	t I.				the cause of death	
requii	ge	Ce.		-4 2421	TED	74 > 5-1	<u> </u>			1 🗆 1	′es 2∐	No 3∐ Pro	obably Unkn	iown
e law has b	Completed									24a. Was autop		24b. Were aut prior to c death?	opsy findings avail ompletion of cause	lable e of
n: Th ficate r, pag		05 111	4							1 □ Yes	No		2 □No	
/sicia s certi	Be	25. Was case referred t examiner? 1 ☐ Yes No	1	lospital:	atient 2 🗆	ER/Outpatien	t 3 DOA Oth	er.		h <i>(Check only o</i> ome 5 ☐ Resid		Other (Cree		
g Phy er thi	Ë	27. Manner of Death	_	28a. Date of I		28b. Time of Injury				28d. Describe h			aiy)	
endin ath. or: Aff he fur	atio	2 Accident	Pending investigation	(WOTAT,	Day, rear)	Injury		Yes 2	□No					
or Atter de irector n by ti	Certification: To	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of building,	Injury - At ho etc. (Specif	ome, farm, stre	eet, factory, office			28f. Location (8 City or Tox	Street and I vn, State)	Number or Ru	ral Route Number,	
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Hos 24 hc Fune etely 1	Medical	29a. Certifier (Check only one)			s of examina		occurred at the ti restigation, in my							
To the within To the сотрі	Me	29b. Signature and title	of certifier				29c. Licens	e numbe	r			signed (Month		
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		30. Name and address				n 23a) (Type, I	Print)	, ,	10 11				20 2147	~
		DOUGLAS		1.			1471 CAL	- 62	" ZIC	74 A		CUS M	20 2140	
State Registra	~	31. Date filed (Month, D	Day, Year)	32. Hegi	strar's Signa	San K	2.8							

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 21 **Physician** 2009 11:40 AM lan A AQUAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3410 CHRISTOPHER BALTIMORE COURI SINDSOR MILL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 □ M 2 🕶 F 213-47-5728 MAY 26, 1999 MARYLAND 0 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Machical Examinar must be notified at 1 ☐ Yes 2 X No Directo BALTIMORE MARYLAND WINDSOR MILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? COURT U.S.H CHRISTOPH*ER* 3410 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify ģ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) STUDENT NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANTWAN DARLENE ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (MOTHER) 3410 CHRISTOPHER COURT, WINDSOR MILL, MD 21244 DARLENE GAITHER 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of column Pamalary or Billian Jr.) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 07/30/2009 5 ☐ Other (Specify) BALTIMORE, MARYLAND 4 ☐ Domation Name and Address of Facility ature of Funeral Service Licens BALTO. 1 M. 1 2/2/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical attending philosopher at the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 → No Year Month 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 2 pas Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital Other: 4 \(\sum \) Nursing Home 1XXYes 2XXXNo 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Medical Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending I hours after death. uneral Director: Aft ely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, 29c. License number ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who come usan MD elman 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 29 Barks Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 27, 2009 5:15 A M July Warren Jackson Hays, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 13, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 X M 2 □ F Maryland 88 219-05-5838 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or 21093 USA 2525 Pot Spring Road, K204 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 Widowed 4 Divorced White n and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Metal Finishing 12 Electroplator n/a filed \ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be 1 William Caroline Johnston John Havs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Road, K204, Timonium, MD 21093 Anne V. Hays/Wife Balthmoré, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition of Department of Important; If its any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/28/09 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Maryland uneral Sorace License 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 21. Signatur Bryan W. 23a. Part1. Enter thé dis lase, or complications (hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail, re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau-e (Findisease or condition resulting in diath) **Physician** Ideablew /Medical lextensive chest/modisshining Due to (or as a consequence of): likelywars Examiner mont unknown Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner burial-transit executer war trions Interna and that initiated events resulting in death) Last Due to (or as a consequence of): limitary Hood frow. Box 68760, attending physician for use as the burial pe Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year 5 Other (specify) P.O. the 1 ☐ Yes 2 ☐ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an cate has by page 2 s performed? Yes 2 No certificate 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to predical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ER/Outpatient 3 DOA မ this nours after death.

neral Director: After this filled in by the funeral di 27. Manner death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0.0 408988 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Book Nove, MI shvipali Parel 1010 31. Date filed (Month, Day, Year) State Registrar

			_ State	State of Maryla		artment of H				09	241	01
		-	Registrar 1. Decedent's Name (First, Middle, Last)	-	061	inicate of L	Jean	2. Date of Death	g. No.		3. Time of	Death
	Physicia	an .		1				Month	Day	Year		рМ
1000	/Medic		John Samuel Howel 4a. Facility Name (If not institution, give stre			4h City Town or	Location of Death	July	22, 2 4c. County	009	3:38	Ъ
	Examin	er					Location of Death		Prince		×~~	
¥-			Laurel Regional H 5. Social Security Number 6. Sex		s. last birthday)	Laurel if Under 1 Year	If Under 24 Hrs.	8. Date of Birth				r Foreian
	Funeral Director	1	·	2□ F	78 Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 4, 1	Year) 931	Count	ace (State of try) WV	7
ц.			Usual Residence of Decedent		, ,							
	/land		10a. State 10b. County	10c. C	City, Town or Lo	cation				10	d. Inside Cit	y Limits
	Man -f sh fled	to	MD Anne Arund	el L	aurel						1 ☐ Yes	2 XNo
	r 282	Director	10e. Street and Number		_	10f. Zip Code		10	g. Citizen of W	/hat Count	try?	
	h with		6 South Paula St.			20724			USA			
	ms 2	Funeral	11. Marital Status	Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-		- America		
٥	after or Ite		1 ☐ Never Married 2 ☑ Married	1 ☑ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2X No	Specify:	riidan, etc.,	Specify.	k, White, e	alG.	
5-0036	within 72 hours after death with the Maryland ene. Itan "natural" or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		12100 12110	орсону.			wh.	ite	
ភ្ន	72 h 'natu dlca	Completed	15. Decedent's Educat (Specify only highest grade c	ion ompleted)	(Give	dent's Usual Occupa kind of work done o	during most of work		16b. Kind of Bu	siness/Ind	ustry	
7	vithin ne. han	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	,		_			
Z	e filed w al Hygie other t vent, th	ပိ	17. Father's Name (First, Middle, Last)		Taxi	Cab Drive	∋r 18. Mother's Nam	a (First Middle A	Transp		tion	-
פעב	be find half	Be		in Herrell					iaiden Sumam	e)		
$\frac{8}{5}$	2 should be f and Mental H is marked of raumatic eve	은	Charles Frankl		405 14-15-		Emiline		O1 T	04-4- 71-	0-4-1	
Maryland	12 st h and 7 is n traun		19a. Informant's Name/Relationship (Type. Nancy E. Howell/ Wi			ng Address <i>(Street a</i> th Paula				siale, zip	Code)	
o,	1 and Healt Sm 2,		20a. Method of Disposition						20 / 2 4 20c. Location -	City or To	wn State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🛣 Cremation 3 ☐ Ren	loval from State		sition (Name of natory or other place	e) July	27,		-	m, olato	
	t. Pa rtmer rtant:		4 □ Donation 5 □ Other (Specify)	We		del Crem.			Odentor	•		
g	Deparament of the property of		21. Signature of Funeral Service Licensee	MOIO		2. Name and Addres				Home	, P.A.	
-			yillen Sula.	M010		13 Talbot					Annrovimat	
			23a Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the de cause on each line.	ath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Bet Onset and D	ween Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Congestive	Heart	Failure				1.	5 minu	
alle,	/Medical Examiner		resulting in death)	Due to (or as a conse								
	4	lan.	Sequentially list conditions, b.	Renal Fail Due to for as a conse								
	ted	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury		a fuerice off							
	and and l-trar	xau	that initiated events c. resulting in death) Last	Diabetes Due to (or as a conse	equence of):							
3/60	centificate be executed iding physician and ise as the burial-transit			,								
28	icate phys s the	dical	d									
×	leath certifica attending ph for use as th	sician/Me	IF FEMALE: 23c	. If yes, outcome pf preg	ınancy				23d Dat	e of delive	n/	
POX	death e atten	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe		Ectopic pregnancy Other <i>(specify)</i>	1		Moi		,	Year
o	the d y the ched	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		, , , , , , ,						
J.	that the de ned by the a detached f	/ Phy	Part II. Other significant conditions contri	buting to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contr	ibute to th	e cause of d	eath?
g D	law requires that as been signed b 2 should be det	d by	Cirrhosis of Liver					1 □ Ye	s 2 No	3 ⊠ Prob	ably 4 □U	Jnknown
<u></u>	w rec	lete	COPD					24a. Was ar	1 24b V	Vere auto	osy findings	available
Kecords,	sician: The law certificate has b irector, page 2 s	Completed						autops perform	y ned?	rior to cor leath?	npletion of ca	ause of
Vital	n: T fficate or, pa	e Co	Coronary Artery Dis	sease			OC Plans of Pass	1 Yes 2 th (Check only on		∐Yes	2 N 0	
	Physician: r this certific ral director,	m	examiner?	spital: 1 ☐ Inpatient 2	ER/Outpatier	ot 3 DOA Oth	or:	ome 5 ☐ Reside		(0:6		
Ö	ing Phys After this funeral di	. To	27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe ho			<u>') </u>	
O	ttending Ph leath. tor: After th the funeral	tior	Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □No					
IVISION	Attending r death. ector: After by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of injury - At	home, farm, str	eet, factory, office		28f. Location (St.		er or Rura	I Route Num	nber,
É	after after d in t	erti	4 ☐ Homicide determined	building, etc. (Spe	ciry)			City or Town	i, State)			
	ie Hospital or Attendi 124 hours after death. Ie Funeral Director: 4 bletely filled in by the fi			ian: To the best of my k								
	To the Hos within 24 ho To the Func completely f	Medical	(Check only 2 Medical Examine one)	r: On the basis of exami and manner stated.	ination and/or in	vestigation, in my o	ppinion, death occu	rred at the time, d	ate and place,	and due to	the cause(s	1)
	To the within To the Comp	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed	(Month,	Day, Year)	
-			1 Com 1.1.	2. 00.	<i>_</i>	0	22966		7/23	/	G	
/	H		30. Name and address of person who com	pleted cause of death (It	em 23a) (Type,	Print)			1	200	1	
5	17.1		Thomas H. Burguiere	MD, 730	0 Van Di	usen Road	, Laurel	, MD 2070	07			
	Sta		31. Date filed Worth Day, Year 19 2009	32. Registrar's gg	nature							
	Registr	ar	W A COOO /		11							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 ther of Mary and / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 25, 2009 5:05 С. Ronald Hooper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 28, 19 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min. 020-34-7404 62 1946 Massachusetts Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f shov Exeminer must be notified at 1 ☐ Yes 2 🙀 No Directo Marvland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 9250 Perfect Hour 21045 Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Inst. If flean 27 is marked other than "natural", or items 23st int. If item 27 is marked other than "natural", or items 13st Iny or other traumatic event, the Medical Extraint in an and in the contract of the 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No IfYes, Give Year or Dates: Vietnam 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🕅 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Military 12 Signal Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hooper Amelia ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane V. Hooper (wife) 9250 Perfect Hour, Columbia, MD 21045 20b. Place of Disposition (Name of Baffamilary crematory of other place)
Baffamilior e Crematory
@ Loudon Park 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If its any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/28/09 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PONTO EMPORAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 Be Certification: To 2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending housian and Division of Vital Records, P.O. Box 68760, been signed by the should be detached certificate has breaking the rector, page 2 s within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

with the Maryland

Baltimore, Maryland 21215-0036

111	ITKT1+2				24a. was an autopsy performed?	24b. Were autopsy indings available prior to completion of cause of death? 1 □ Yes 2 □ No			
	referred to medical			26. Place of Dea	th (Check only one)				
examiner? 1 ☐ Yes	2 No	Hospital: 1 ☐ Inpatient	P ☐ ER/Outpatient 3 ☐ I	ome 5 ☐ Residence 6	me 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of I 1 ☑ Natura 2 ☐ Accide	l 5 ☐ Pending investigation		r) 28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred			
3 ☐ Suicide 4 ☐ Homici	datarminad		at home, farm, street, factor ecify)	ory, office	28f. Location (Street and City or Town, State)	f Number or Rural Route Number,			
29a. Certifier (Check onlone)				ed at the time, date and place on, in my opinion, death occu		and manner as stated. place, and due to the cause(s)			

29c. License number

D67788

29d. Date signed (Month, Day, Year)

7.27.2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAO KODALI 14090 HG Trueman Rd Suite 2300 Solomons, MD 20678 LEENA

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27,2009 11 Р July James O. Hatcher 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 3530 Resource Dr. Appt.225 Randallstown 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours Min Maryland 1 Q M 2 □ F Nov. 219-22-8454 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State Baltimore Randallstown ¥ Yes 2□No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3530 Resource Dr. Apt.225 21133 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Marmy
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify:black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry
Fort Howard Veteran 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital 12th Paramedic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James O. Hatcher Etta Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1349 Silverthorne Rd. Balto, Md. 21239 Bernard Hatcher (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veteran Cem. Owings Mills, Md. 20a. Method of Disposition MyBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213 23a. Part1. Enter the disease, or complications that caused in death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 years Dilated Cardiomyopathy disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of if any, leading to inmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. rabetes 1 Tes 2 No 3 Probably 4 Unknown ementia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe PS A 1 ☐ Yes 2 No Elevated 1 ☐Yes 2 No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Exeminer must be nothing at

Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other I any Injury or other traumatic event, In

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine burial-tran Physician/Medical ð Completed

and physician a attending phi for use as the cate has been signed by the page 2 should be detached certificate funeral director, Be Certification: To this After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records.

and manner stated.

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

(Check only one) 29b. Signature and title of certifier

29c, License number D 0055698

Baltimore

29d. Date signed (Month, Day, Year) 29th, 2009

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 N. Greene St. Sungyon M.D (

31. Date filed (Month, Day, Year)

32, Registrar's Signature

M-D

State

Medical

			For State Registrar	State of M	laryland /	•	rtment tificate			nd Me		ene g. No.	09	24404
	Physici /Medio		1. Decedent's Name (First, Middle GRACL Powle	W Hillia	evd						2. Date of Death Month	Day	89	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution English Coult 5. Social Security Number 55914 7784	Life Can		oirthday) Yrs.	4b. City, To ANN If Under 1 Months	AF	If Under 2	S4 Hrs.	8. Date of Birth (Month, Day,	Year)	Cow	olace (State or Foreign fromia
	ט	tor	Usual Residence of Decedent 10a. State 10b. County	Arunde1	10c. City, To	wn or Lo						720		0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28a	i Director	10e. Street and Number 4000 River Cre	scent			10f. Zip 0	2140	01		10	Og. Citizen	of What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any njury or other traumatic event, the Medical Examinar must be notified at ORGS.	by Funerai	11. Marital Status 1 ↑ Never Married 2 → Married 3 → Widowed 4 → Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	? No		Vas Decede Yes, specif	_	spanic Orig n, Mexican, Specify:	in? (Spec Puerto P	city Yes or No- lican, etc.)		Race - Americ Black, White, ecity: Whi	etc.
Maryland 21215-0036	within 72 horiene. iene. rthen "nature	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12) 12			(Give	lent's Usual kind of work DO NOT use	done di retired)	uring most	of workin	g	16b. Kind o	f Business/In	_{dustry} unk
land 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Robert Bell Hi		dr USN)						(First, Middle, M Powe11	Maiden Sun	name)	
	and 2 sho salth and N n 27 is ma		19a. Informant's Name/Relations John Morrisc			22 S	evern	Way			, MD 2	City or To	wn, State, Zip	Code)
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S	pecify)	ceme		sition (Name natory or oth)	Da	ite :	20c. Locatio	on - City or To	own, State
Ball	permit Depart Import any n		21. Signature Funeral Service South	MAYUU		Ba	1timo:	re,	MD = 2	1201	655 W.		more S	
	Physician /Medical		23a. Part1. Enter the disease, or shock, of heart failure. List Immediate Cause (Final disease or condition resulting in death)	_ a V	Dem	ení	or the mode	of dying	, such as o	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
8760,	te be executed was a system and we burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequence s a consequence s a consequence	ea of):	V a	15	ery	di	(enll			¥/Ş.
Division of Vital Records, P.O. Box 68	Attending Physicien: The law requires that the death certifica relath. reteath. ector: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		e of pregnancy 2 ∏Fetal dea at time of death		Ectopic pre					23d.	Date of deliv Month	ery Day Year
rds, P.	quires that an signed by uld be deta	þ	Part II. Other significant condition	ons contributing to death	but not resulting	in the ur	nderlying ca	use give	n in Part I.			accouse o	_	he cause of death?
al Reco	i: The law requiri icate has been si i, page 2 should I	Completed									24a. Was a autops perform	V	tb. Were auto prior to co death? 1 🗆 Yes	opsy findings available impletion of cause of
f Vit	ysicier is certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:	tient 2 ER/	Outpatien	t 3 DOA	Cthe	- 1		(Check only on ie 5 ☐ Reside		Other (Speci	(y)
sion o	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	gation	ury 28b ay Year)	o. Time of Injury	28 M	ic. Injury Work 1 🔲 Y	at ? ′es 2 □ N	- 1	8d. Describe ho	w injury oc	curred	
DİX:	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could determ	ined 286. Place of I building,	njury - At home, atc. (Specify)						City or Town	n, State)		al Route Number,
	To the Hoepital or within 24 hours atte To the Funerat Direction completely filled in h	ledicai	(Check only 2 Medical one)	Examiner: On the basis and manner:	of examination		estigation, i	in my op	inion, deat	h occurre	d at the time, d	ate and pla	ce, and due t	o the cause(s)
)	To Tool	Σ	29b. Signature and title of certifier	=m/			29c.	License	H19	78	7	9d. Date si	gned (Month, -24-	Day, Year) 2009 110 M 0 20769
			Name and address of person	avaKOli	1220	0 1	Print)	a po	lis	Rd	# 220	8 6/	enn D	11e M) 20769
	Sta Regist		31. Date filed (Month, Day, Year)	- A	trar's Signature	back	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 101 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospice-NW Baltin andaustown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Manth, Day) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1□M 2XF NC 228.07.4558 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 23a or 28a-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Kaltino Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3618 21207 Telmar Load Funeral Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Black Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8th grade 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Keumey eola Moss Pages 1 and 2 should ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Heath ar
Important: If Item 27 Is
any injury or other trau 3618 Telmar Road Baltimore MD 21207 Josie Moulton 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Windsor Nill, MD 08/04/09 King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Vaughor C. Greene Funeral SNG 21. Signature of Funeral Service Licensee 22. Name and Address of Facility C. Gree 8728 L Road ND 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** OM /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-tran Box 68760, Due to (or as a consequence of) ned by the attending physician detached for use as the buria Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Ö 9 Unknown 9 Unknow signed by ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, nknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has page 2 s autopsy performe certificate 1 ☐Yes 2 XNo of Vital Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To HOXAC 27. Manner of Feath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

3

State Registrar

31. Date filed (Month, Day, Year)

JUL

20 2000

BMD 23
33 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 per me, 2893, 07/30/09dnb

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	Physici	an	1. Decedent's Name (First, Middle, La	·					2. Date of D Month	Day	y Year	3. Time o	
	/Medic		Philip Wood Kor						July	26,		1:24	РМ
	Examin	er	4a. Facility Name (If not institution, giver Anne Arundel Me		0.76		4b. City, Town, or Annar		eath	4c.	County of Deat		
~ Pr **	Euporol		5. Social Security Number 6. S		e (In yrs. las	birthday)	If Under 1 Year	JOLLS If Under 24 H	Irs. 8. Date of B	irth		_	or Foreian
	Funeral Director			X M 2□ F	81	Yrs.	Months Days		Irs. 8. Date of B in. (Month, D Dec 24	(4, 19)	927 Oh	hplace (State untry) 10	
	land ow		10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside C	City Limits
	Mary a-f sh	tor	Maryland Prince G	eorge's		Во	owie					1 □Yes	2 🔀 No
	or 28	Jire	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	untry?	
	23a unit b	Funeral Director	12304 Madeley Lan	e			20715	5			USA		
	tems	nne	11. Marital Status	12. Was Decedent E Armed Forces?	101	13.	Was Decedent of H	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ame Black, White		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Medical Event for must be notified an once.	by	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	194 194		1 □Yes 2 X INo	Specify:			Specify: W	hite	
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121	vithin ane. han	ldm	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT use retirea	1)		Topod	ا مشموط ما	Chami] .
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ī	should be and Mental s marked o umatic eve	2	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street a			ber. City o	or Town, State, 2	Zip Code)	
Š	and 2 ealth a n 27 is		Barbara Kornreio	h. Wife			Madeley			_			
ore,	es 1 a of He of He rothe	- 3	20a. Method of Disposition	•	20b. Plac	e of Dispo	sition (Name of natory or other plac	re)	Date		ocation - City or		
fltimore ,	Pages nent of ant; If its ury or o		1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Specit</i>		1		ematory In		/27/09	 Bal	ltimore,	Marvl	and
BÆ	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	Thomas		2	Name and Address Cremation	Society	y Of Mary	yland	i, Inc.		
	222 60		23a. Part 1. Enter the disease, or com	light that assessed	the death		99 Freder				<u>Maryla</u>		
E			shock, or heart failure. List only	one cause on each lin	e.	Jo not em	er trie mode or dym	Seps		arrest,	-	Approxima Interval Be Onset and	tween
1	Physician /Medical		disease or condition resulting in death)	a. 114		£ 6	o crdos	т верг	313			Tref	
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		ner	Sequentially list conditions, if any leading to immediate	b. Due to (or as a		ce of	cit	^	1 /11	<i></i>	AMINER		
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90,	oe execian a		resulting in death) Last	Due to (or as a	consequen	ce of):		CERTIFICATIO	W Walter				
68760,	rtificate be executed ng physician and as the burial-transit	Medical		d									
× 6	certifi nding ise as		IF FEMALE:	23c. If yes, outcome of	of pregnance	,					22d Date of del	been	
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	res that signed I be det	by P	Part II. Other significant conditions of	ontributing to death bu	t not resultir	ig in the ui	nderlying cause give	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of	death?
Ş	w require been signatures		acate 185	p tento-	e				_ 1 🗆	Yes 2	□ No 3□ Pr	robably 4 🗩	Inknown
Division of Vital Records,	law re las be 2 she	Completed	septe st	wek.					24a. Wa	s an	24b. Were au	topsy findings	available
<u>=</u>	sician: The law certificate has b irector, page 2 sl	Con	tate abd	2 minus	cat	05/1	england.		perl	ormed?	death?	2 □No	
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	A familiali					Death (Check only				
of	Phys this a	<u>۽</u>	1X Yes 251No 27, Manner of Death				nt 3 □ DOA Othe	4 ⊔ Nursing	g Home 5 ☐ Res			cify)	
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18	Atten deatl ctor: y the	fical	3 ☐ Suicide 6 ☐ Could not b		rv - At home	. farm. str		— Z 🗀 NO	28f. Location	(Street an	nd Number or Ru	ıral Route Nur	nher
2	al or a after I Dire	Certification:	4 Homicide determined	28e. Place of Inju building, etc.	(Specify)		,		City or To	wn, State)		
	To the Hospital or Attending Physician: within L24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p		29a. Certifier (Check only 2 Medical Exar	ysician: To the best on the basis of	f my knowle	dge, deatl	n occurred at the tir	ne, date and pla	ace, and due to th	e cause(s	and manner as	s stated.	e)
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	10x1)		Jel Veli	un mis	-11- (1)		02	4864			26-2	007	
	6.		30. Name and address of person who Robert Pe. 1	completed cause of de	eath (Item 23	a) (Type,	Print) - MC	1	ale n	10	21401		
*	Sta	ie_	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1-1	1	May	//> //	11)	2.101		
	Registra		111 2 9 2009	12	19 1	Dark							

09-05793 Jane Kubas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Mar Natio / Department of Theath and Mental Hygiene

Physician cal Examin		1- For State Registrar	Certifica	ate of Death		Reg. N	. 200	0 011			
X3111111	n/	1. Decedent's Name (First, Middle,Last) Jane Kuba	5			2. Date of Death Month Day July 24, 2009	Year	3 Time of Death 2011 hrs			
		4a. Facility Name (if not institution, give stree		4b. City, Town, or	Location of Death		4c. County of Death	1			
		11217 St. Martins Parkway		Berlin	Larine in casin	Worcester der 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Fore					
Funeral Director		5 Sacial Security Number 155-80-9593	7. Age (In yrs. last birth	Months Days		10/02/19	Co	untry) NJ			
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits			
*	٦	Maryland Worcester			Berlin			1 Yes 2 X No			
Maryland 28a-f show d at once.		10e. Street and Number		10f. Zip Code		10g. C	itizen of What Cou	ntry?			
ith the Maryland 23a or 28a-f sho notified at once		11217 Saint Martins		13. Was Decedent of His	21811	ocify Vec or No.	USA	ican Indian, Black,			
r death wi	Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?	If Yes, specify Cuban			White, etc.	ican indian, black,			
of nor m	by Ft	3 Widowed 4 X Divorced If Yes	Yes 2 No	1 Yes 2 X No	specify:		Specify: W	hite			
hours a		15. Decedent's Education (Specify only hig		Decedent's Usual Occupat during most of working life			, Kind of Business/	Industry			
in 72 lin 72 lin 4 dical l	plet	Elementary/Secondary (0-12) C	College (1-4 or 5+)	Homemal	kor		House	ehold			
be filed within 72 hours at the filed within 72 hours at the Hygiene. Red other than "natural ent, the Medical Examin	Completed	17. Father's Name (First, Middle, Last)				(First, Middle, Maid					
Mental Filmarked	Be		llen Jr.			P. Bel		-			
2 P 2 T 1] ع	19a. Informant's Name/Relationship (Type, F Edna P. Chew (mother)	o. Mailing Address (Stree 40 S Broad S	Street, A	pt #400,	Penns Gro	ove, NJ 080			
ages 1 and 2 sl nt of Health ar it; If item 27		20a. Method of Disposition 1 Burial 2 Cremation 3 Re		of Disposition (Name of cer ory or other place)	metery, Ju]		c. Location - City or	Town, State			
permit. Pages 1 ar Department of Hee Important; If ite Injury or other tr		4 Donation 5 Other Specify:		l Lawn Crema		2009 U	pper Deer	field, NJ			
permit. Pages 1 Department of 1 Important; If i		21. ig ture of Funeral erv / icens	}.	22. Name and Address 3111 Mour	•			Home, P.A.			
Physician		23a. P rt l. Enter le disease, or comi lic ti	ns that caused the death. Do no					Approximate Interval			
/Medical Examiner			e. ethadone Intox: o (or as a consequence of):	ication				Death			
		Sequentially list conditions, b									
	Examiner	cause. Enter Underlying Cause	o (or as a consequence of):								
D ₂ ⋅ ₹	ä	(Disease or injury that initiated events resulting in death) Last	o (or as a consequence of):								
executed in and il - transit		UNPENDED d.	ENDED 23a,pt.II,	,27,28a-f pe	r me g894	8-20-09	vt				
ate be excopysician	Medical		c. If yes, outcome of pregnancy				23d. Date of deliver	ry			
eath certific	sician/	23b. Was decedent pregnant in the past 12 months?	D	Fetal death 3	Ectopic pregna	ncy	Month	Day Year			
e death the atter	ysic	1 Yes 2 No 9 V Unknown 9	Unknown	5 Other (Specify)							
res that the signed by the be detache	by Phys	Part II. Other significant conditions conti	ributing to death but not resulting	g in the underlying cause	given in Part I.			the cause of death?			
by F. C. Lines that an signed ald be deta	ed b	Cocaine		·		and the second		bably 4 Unknown			
shou	plet		-			autopsy	prior to	completion of cause of			
2 % % % S	5			00 P/	15 11 (0)	1 🗸 Yes 2	No 1 🗸 Y	es 2 No			
The law	a	examiner? Hospit	al: 1 Inpatient 2 ER/O		I Outhorn		sidence 6 🗸 Othe	er: Scene			
sician: The law is certificate has irector, page 2	O 1		28a. Date of Injury 28b.		ury at Work?	28d. Describe how	injury occurred				
of Vital Necolus, g Physician: The law requir fler this certificate has been: neral director, page 2 should		1 Natural 5 Pending	· · · · · ·	55 hrs.	Yes 2 X No	unknown					
tending Physician: The law eath. tor: After this certificate has the funeral director, page 2.			28e. Place of Injury - At home, fa		building, etc.	28f. Location (Stre or Town, State	et and Number or R 11217 St	tural Route Number, Cit Martins F			
or Attending Physician: The law after death. Director: After this certificate has din by the funeral director, page 2.		3 Suicide 5 X Could not be									
DIVISION OF VICENTIAN RECOIDS, F. C. BOX 002 oppital or Attending Physician: The law requires that the death certific hours after death. Internal Director: After this certificate has been signed by the attending by filled in by the funeral director, page 2 should be detached for use as the state of the	Certification:	Suicide 6 X Could not be determined 4 Homicide determined	(Specify) residence	ath accurred at the time of	late and place, and	due to the cause/s	and manner as sta	ted			
The Hospital or Attending Physician: The law within 24 hours after death. The Funeral Director: After this certificate has implicitly filled in by the funeral director, page 2.	Certification:	Suicide 4 Homicide 29a. Certifier (Check only one) Wedical Examiner: On t	To the best of my knowledge, de the basis of examination and/or i	eath occurred at the time, dinvestigation, in my opinion	late and place, and n, death occurred a	due to the cause(s t the time, date and) and manner as sta place, and due to t	ited. he cause(s)			
ing Page		Suicide 4 Homicide 29a. Certifier (Check only one) Wedical Examiner: On t	To the best of my knowledge, de	eath occurred at the time, dinvestigation, in my opinion 29c. Licens	n, death occurred a	t the time, date and	and manner as starting place, and due to to detect the detect of the det	he cause(s)			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	Suicide 4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On t and	To the best of my knowledge, de the basis of examination and/or i	investigation, in my opinior	n, death occurred a	t the time, date and	place, and due to t	he cause(s)			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	Suicide 4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On t and 29b. Signature and title of certifier 30. Name and ad ress of person who complete	To the best of my knowledge, de the basis of examination and/or imanner stated.	investigation, in my opinion 29c. Licen: O.C.	n, death occurred a se number .M.E.	t the time, date and	place, and due to to ded. Date signed (M	he cause(s)			
Ø	Certification:	Suicide 4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On t and 29b. Signature and title of certifier 30. Name and ad ress of person who comple Russell Alexander MD. Assi	To the best of my knowledge, de the basis of examination and/or imanner stated.	29c. Licens O.C.	n, death occurred a se number .M.E.	t the time, date and	place, and due to to ded. Date signed (M	he cause(s)			
require	To Be Completed	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year) 7-24-09 19	DOA Time of Injury 28c. Inju 55 hrs.	Yes 2 X No building, etc.	performer 1 ✓ Yes 2 2 yes 2 2 yes 2 2 yes 2 2 yes 2 2 yes 2 2 yes 2 2 yes 2 2 yes 2 2 yes 2 2 yes 2 2 yes 2 2 yes 3 2 yes 3 2 yes 4 2 yes 2 2 yes 4 2 yes 2 2 yes 4 2 yes 2 2 yes 4 2 yes 2 2 yes 4 2 yes 2 2 yes 4 2 yes 2 2 yes 4 2 yes 2 2 yes 4 2 yes 2 2 yes 4 2 yes 2 2 yes 4 2 yes 4 2 yes 2 2 yes 4	prior to death? No 1 V sidence 6 V Other injury occurred at and Number or R 11217 St	r: Scene tural Route Number, Martins			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc 8893 7-30-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day $\underline{A}^{\mathsf{M}}$ **Physician** 2009 4:45 23, John Kane July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Oct. 17,1934 5. Social Security Number 6. Sex 1 🛣 M 2 🗆 F 7. Age (In yrs. last birthday) **Funeral** Days Months Hours New York 74 073-26-5058 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it at Medical Execution to notified at 1 ☐ Yes 2 X No Director MD Timonium Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 2201 Foxley Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 57 ' -62' 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify Specify: White Š 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Food Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Frank Kubiak Estelle Pokrywczynski ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2201 Foxley Road Timonium, MD 21093 Inez Kane/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 26, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State any injury or Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Burnie, MD 21. Signature of Fune 22. Name and Address of Facility, Lemmon Funeral Home of Dulaney Valley 10 W. Padonia Road Timonioum, MD 21093 chaol J. Flagle Approximate Interval Between Onset and Death 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** acute husocardia infaction minutes /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner requires that the death certificate be executed tran and resulting in death) Last Due to (or as a consequence of): burial-Box 68760, physician the burial Physician/Medical d guipt IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for u 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o. 9 I Inknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 Yes 2 1NO of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be subacul Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 this After thi 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After the completely filled in by the funera Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D24121 30. Name and address of person who completed cause of death (It 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

21 WEST

RD

05 ENBERG

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician July 23°, Year 2009 10:30 pm GERALD RHONE KUHN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Bay Ridge Health Care Center Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Dec. 24, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1∏M 2□F Days Hours Min. 231-54-9013 1942 66 Director Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Director MD NYes 2 □ No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or death with 20707 U.S.A. 1111 Beall Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Extra Black, White, etc. 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2XXNo Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Freight Rate Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Lillian Hayton George Ronald Kuhn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Becky R. Kuhn spouse 1111 Beall Place Laurel, Maryland 20707 20b. Place of Disposition (Name of Wallhut cromatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State WXBurial 2 ☐ Cremation 3 ☐ Removal from State God Cemetery 7/28/2009 Maddensville, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, ome, P.A. Laurel, _M00770 313 Talbott Avenue Maryland 20707 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final Atherosclerotic Cardiovascular Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): death certificate be executed that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 Cther (specify) ed by the a 1 Tyes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, signt be c Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ ★ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autoosv perform 2 **XX**0 1 □Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 XIo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 🛛 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only within 2 one) and manner stated 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 2006368 July 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V Ajit Kurup, MD, 1835 University Blvd., East, #208, Hyattsville, Maryland 32. Registrar's S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 25, 2009 4:30 A M July Elizabeth Marlene 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Gambrills Anne Arundel 2274 Dairy Farm Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1 □ M 2 🗓 F New York Oct 28, 1938 71 136-30-3619 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No Gambrills Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21054 United States <u>2274 Dairy Farm Road</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Church School 12 Preschool Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Ada Tler Harold Joseph Musante Iris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2274 Dairy Farm Road Gambrills, Maryland 21054 David D. Keck/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 7/29/2009 Odenton, Maryland 21. Sign a re of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, Thomas 1411 Annapolis Road Odenton, Maryland 21113 M00957 23a. Partit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1640-240 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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ed other than "natural", or items 23a or 28a-f sho event, tre Medical Evans in must be notified at

permit, Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than 'any injury or other traumatic event, the Magnesia.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

attending physician and for use as the burial-tran as the is certificate has been signed by the director, page 2 should be detached s after death.

Hospital or Attending Physician; The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Examiner Physician/Medical ≥ Completed Be Certification: To completely filled in by the funeral

Medical

IF FEMALE

29a. Certifier

(Check only

27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 Suicide 4 Homicide

1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and title of certifies

29c. License number

UNIVOFMD, 22 Screene St.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine TKOLCZUL

and manner stated.

31. Date filed (Month, Day, Year) JUL 29 2009

State Registrar

24 hours a

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25 127, 28 a ryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2009 **Physician** J_{uly}^{Month} 21, 06:35 Barbara Stone Larimore /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Sept 30, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Sept" 1 □ M 2 V F 80 201-18-6285 PΆ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Madical Examinatorial be notified at once. 10d. Inside City Limits 10a State 10c. City, Town or Location Woodbine 1 □ Yes Ž□ No MD Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21797 USA 3425 Hipsley Mill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2∭XNo Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Substitute Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Winn Stone Jesse Η. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3425 Hipsley Mill Rd., Woodbine, MD 21797 Mr. Alanson L. Larimore (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/25/2009 Glenwood, MD Oak Grove Cemetery 21. Signature of Funeral Service License HAIGHT FUNERAL HOME & CHAPEL, P PO Box 195 Sykesville, MD 21784 400764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician pheumonia disease or condition resulting in death) /Medical Examiner Sequentially list conditions, CERTIFICATION APPROVED BY MEDICAL EXAMPLES Examiner if any, leaving to himself cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dicheks wellitus 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed certificate has been rector, page 2 should interstities lung 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Subject fell 28c. Injury at Work? 1 Natural 5 Pending 07/04/2009 **Unknown**M 1 □Yes 2X No 2 Accident off of a chair. investigation s after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 3425 Hipsley Mill 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Home Road, Woodbine,MD within 24 hours a

To the Funeral (
completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi D0651684 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) blondward Court Olney, MD 20832 Brice Knolmayer MD 3414

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 29 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last, Month 5:22 PM 2009 23 **Physician** amono narew /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) March 21, 1934 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Massachusetts 024-26-4082 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 23a or 28a-f show 1 ☐ Yes 2X No Howard Columbia Directo Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or U.S.A. 21044 10310 Swift Stream Place #105 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Black, White, etc. 1 X Yes 1 Never Married 2 Married 1 ☐ Yes 2xxNo Specify Specify: White Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Is marked other than Electronics Salesman traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred J. Hickey Ignatius F. Lamond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10310 Swift Stream Place #105 Columbia, Maryland 21045 (Partner) Richard A. Gross other permit. Pages 1 and Department of Healt Important: If item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Sykesville, Maryland Lakeview Memorial Park 7-28-2009 4 ☐ Donation 5 ☐ Other (Specify) injury o 22. Name and Address of Facility Witzke Funeral Homes 21. Signature of Funeral Service Licensee any ir Inc. 5555 Twin Knolls Road Columbia, MD 21045 23 Fart 1. Enter the se se complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiac Arrest Immediate Cause (Final disease or condition resulting in death) Physician /Medical Cardiogenic Shock **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Infarction Myocardial Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and physician and as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant Day Month in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown filled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manner of Death 28a. Date of Injury Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 × Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JULY 23, 2009 **RES-000**

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30. Name and ad ss of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

			amend #31 Per 1 1- State Registrar	YN State of	'Märylar		artmer <i>rtificat</i>				1ental H	lygie Reg.	20	09	24413
			1. Decedent's Name (First, Middle	e, Last)							2. Date of	Death	-		3. Time of Death
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			9014 Rhode Is	land Avenu	ıe #207	7			e Par				Prin	ce G	eorge's
	Funeral Director		5. Social Security Number 577–62–0359	6. Sex 1 ☐ M 2 ∏ F	7. Age (In yrs. 64	last birthday) Yrs.	Months		If Under Hours	24 Hrs. Min.	8. Date of Month, June	Birth Day, Ye 13 ,	1945	9. Birthp Cour Wes	olace (State or Foreign ntry) t Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	ocation							-	0d. Inside City Limits
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	3a or		9014 Rhode Isl	and Avenue	e #207		102.,		740			1	JSA		, .
	ms 2	Funerai	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.	Was Dece			igin? (Sp	ecify Yes or Rican, etc.)		14. Race		can Indian,
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of Vital Rec Physician: The law this certificate hes tral director, page 2 s	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ In	patient 2	ER/Outpatient	3□ DO	Othe	r /	a Home 5 □ Resi		er (Specify)	
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DHMH 16 Rev 6/95

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Physicia	n	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month	Day Yes	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 11	Timene	4c. County of D	eath
Funeral Director		5. Social Security Number 6. Sex 1 M 213F 6. Sex 1 M 213F 6. Sex 61 Yrs. 61 Yrs. 61 Yrs. 61 Yrs. 61 Yrs.	8. Date of Birth (Month, Day, Sept.17	Year)	Birthplace (State or Foreign Country) TN
the Maryland 28a-f show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Laurel			10d. Inside City Limits 1 □Yes 2 및No
3a or 28	⋾ ∣	10e. Street and Number 400 Barbersville Road 20724	1	0g. Citizen of What	Country?
33 a s s s s s s s s s s s s s s s s s s	by Fu	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No Specify:	pecify Yes or No- Rican, etc.)		American Indian, /hite, etc. white
21215-0036 ad within 72 hours aft giene. er than "natural", or t, tre Medical Exerti	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work) ilfe. DO NOT use retired) Customer Service Repre		16b. Kind of Busine Banking	ess/Industry
e filed w al Hygie other t	Se -	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, i		
rylar hould be d Menta marked matic e	2	John Thomas Ollie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rur.	Parrot	r, City or Town, Sta	te, Zip Code)
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 Is marked oth any injury or other traumatic evenions.		Douglas Cecil Midkiff/ Husband 400 Barbersville Rd., 20a. Method of Disposition 20b. Place of Disposition (Name of competent growther of a competent growther growt	Laurel,		
ting t. Pa timer tant tant	1	1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crem. 20	30,	Odenton,	MD Home, P.A.
Bal permit Depar Impor any ir		M01053 313 Talbott Ave., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Laurel,	MD 20707	
176(ate be nysicia ne bur	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Severe Cervical Degenerative Disk Disease with Comp	Spine Mu	altilevel	
O. BOX 68 he death certifics the attending pt ched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1		23d. Date o Month	
	Š	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribu ⁄es 2 ☐ No 3[te to the cause of death? Probably 4 Inknown
Re	Completed		24a. Was autop perfor 1 □ Yes	psy prio prior dea	re autopsy findings available or to completion of cause of th? IYes 2
of Vita Physician: this certific	Be	25. Was case referred to medical examiner? 1X Yes 24440 Hospital: 154 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H		ne) dence 6 ☐Other	(Specify)
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Certification: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 20 Accident Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending (Month, Day, Year) 1 Natural 5 Pending (Month, Day, Year) 28 Date of Injury 28b. Time of Injury 38c. Injury at Work? 1 Natural 1 Natural 1 Natural 28c. Injury at Work?	28d. Describe h	now injury occurred	or Rural Route Number,
Divi	al Certif	4 Homicide determined building, etc. (Specify)	City or Tov	vn, State) cause(s) and manr	ner as stated.
o the Ho: ithin 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated. 29b. Signeture and title of certifier 29c. License number	urred at the time,	date and place, and 29d. Date signed (i	d due to the cause(s)
) F 3 F 8		1 P 27/62		JUNE	25 2009
		30. Mame and address of person who completed cause of death (Item 23a) (Type, Print) CHUNTOSAUUL 72 Souru GN 31. Date filed (Month, Day, Year) 32. Registrar's Signature	tout 5	T BAUT	I M 21 9
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Date filed (Month, Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) **Physician** Brian B. Martynowicz /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 2640 Openshaw Road 5. Social Security Number **Funeral** 1**X** M 2□ F 213-78-1866 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Example International Conce. 10a. State 10b. County **Funeral Director** Maryland Baltimore 10e. Street and Number

If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 49 10c. City, Town or Location

White Hall

Baltimore White Hall 8. Date of Birth April Day, Year) April 11,1960 9. Birthplace (State or Foreign Maryland 10d. Inside City Limits

29°

2. Date of Death

July

2640 Openshaw Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 11. Marital Status

10f. Zip Code 21161 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □Yes 2X No

Certificate of Death

4b. City, Town, or Location of Death

14. Race - American Indian, Black, White, etc.

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

3 Widowed 4 Divorced

Be Completed by

၉

Examiner

Physician/Medical

ģ

Baltimore, Maryland 21215-0036

Physician

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi

After this

death.

within 24 hours after death To the Funeral Director: filled in by the

/Medical

1 Never Married 2 Married

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mason

17. Father's Name (First, Middle, Last)

Edmund J. Martin

19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2640 Openshaw Road White Hall, Maryland 21161

Kelly A. Martynowicz, Wife 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. Date 20c. Location - City or Town, State

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Thomas Gregor

lf Yes, Give Year or Dates:

College (1-4or 5+)

07/30/09 Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228

homas

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final

disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Due to (or as a consequence of)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? ☐Yes 2 ☐No 9 Unknown

25. Was case referred to medical examiner?

If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

Due to (or as a conse

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Tes 24a. Was an autopsy

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

3 Probably 4 Unknown

1 ☐ Yes 2 ZNo 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

2 No

Be Completed 1 Yes 2 No Certification: To 27. Manner of Death

4 Homicide

5 Pending investigation 2 Accident 3 ☐ Suicide

6 ☐ Could not be determined

28b. Time of 28a. Date of Injury (Month, Day, Year) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

ath (Item 23a) (Type, Print) Woens EMALES ST

31. Date filed (Month, Day, Year) JUL 3 0 2009

32. Registrar's Signature

State Registrar

ical

DHMH 17 Rev 1/2001

ORIGINAL

10g. Citizen of What Country?

3. Time of Death

8:00 AM

1 □Yes 2X No

USA

Specify: White

20009

4c. County of Death

16b. Kind of Business/Industry Brick & Block

18. Mother's Name (First, Middle, Maiden Surname)

Construction

Dorothy Valiant

Baltimore, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician	
/Medical	
Examiner	

Fune Direc

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physic /Medi Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

	-	1 - State Registrar			•	Cei	rtificate of	Death		Reg. No.	109	24417
		Decedent's Name (Fire	rst, Middle, La	ist)								3. Time of Death
sician edical		William		Jo	seph	Mi	ller	Sr.	July			4:00P M
eaicai minei		4a. Facility Name (If not	institution, giv	ve street and nu	mber)		4b. City, Town,	or Location of Death)	4c. Count	y of Death	
	ı	North Arun	del Re	habilit	ation C	enter				Anne		
ral tor		5. Social Security Number 219-18-324							8. Date of Bir (Month, Da March	th , ^{Yea} [1926	9. Birth	place (State or Foreign ntry) MD
		Usual Residence of Dec										
1 .	.		. County	Joseph Miller Sr. July 27, 2009 4:00F Appearance and number) About 10 Control of Death Annual Interpretation Center Glen Burnie 10 City Town of Location Death Annual Interpretation Center Annual Interpretation Center Glen Burnie 10 Zp Code Glen Specify White Country? 10 Zp Code 11 Zp Was Decoderat Ever in U.S. 12 Was Decoderat Ever in U.S. 13 Was Decoderat Ever in U.S. 14 Reace - American Indian. 15 Was Country of Nove Specify: White 15 Kind of Business Andustry 16 Kind of								
Director	2			undel	G1	en Bur	_				Year 2009 4:00P M	
Par Divoctor		10e. Street and Number								_	What Cou	4:00P M del place (State or Foreign ntry) MD 10d. Inside City Limits 1 Yes 2 No ntry? can Indian, etc. te dustry p Code) own, State ie, MD remation , MD 21061 Approximate Interval Between Onset and Death 3 weeks 3 weeks yery Day Year the cause of death? obably Yunknown opsy findings available ompletion of cause of 2 No ify) ral Route Number, stated. to the cause(s) , Day, Year)
Financial	2	302 Lionsh	eart G			1.0			: /- · · · · · · · · · · · · · · · · · ·		Amai	oon Indian
	5	11. Marital Status	0	Armed Fo	rces?	J.S. 13.	was Decedent of If Yes, specify Cul	2. Date of Death Month July 27, 2009 4:00P M Location of Death 4c. County of Death Anne Arundel If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 926 9. Birthplace (State or Foreign MD) 10g. Citizen of What Country? U.S.A. Ispanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.) Specify: 116b. Kind of Business/Industry Bineer 16c Ark and Number or Rural Route Number, City or Town, State, Zip Code) d Pasadena MD 21122 10g. Citizen of What Country? U.S.A. Ispanic Origin? (Specify Yes or Non, Mexican, Puerto Rican, etc.) Specify: White 16b. Kind of Business/Industry Electric 18. Mother's Name (First, Middle, Maiden Surname) Emma B. Clark and Number or Rural Route Number, City or Town, State, Zip Code) d Pasadena MD 21122 19 Date 20c. Location - City or Town, State 19 O7-29-2009 Glen Burnie, MD Sos of Facility Singleton Funeral & Cremation A 1 2nd Ave. SW Glen Burnie, MD 21061 Ayproximate Interval Between Onest and Death 3 weeks 3 weeks 3 weeks 3 weeks 3 weeks 4 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 24d. Was an 24b. Were autopsy findings availability and the surpost of the cause of death?				
1		1 ☐ Never Married 3 🛱 Widowed 4 ☐		If Yes, Gi	ve _		1 □Yes 2 🗓 No	Specify:		Speci	ify:Whit	e
		15.	Decedent's E	ducation		16a. Dece	dent's Usual Occu	pation		16b. Kind of B	Business/In	dustry
1 2	2	(Specify of Elementary/Secondary	nly highest gr	ade completed)	I-4or 5+)	(Give	kind of work done DO NOT use retire	e during most of wor ed)	king			
Completed	5	12	y (0-12)	Oonege (Elect	rical E	ngineer		Elec	tric	
		17. Father's Name (First	t, Middle, Las	1)				18. Mother's Nan	ne (First, Middle	, Maiden Surna	me)	
		William Thomas Miller Emma B. Clark										
		19a. Informant's Name/	-			1	-				n, State, Zij	o Code)
<u> </u>		Mr David M:		Son								
To Be Com		20a. Method of Dispositi		Removal from	State 20b.	Place of Dispo cemetery, crei	sition (Name of natory or other pla			20c. Location	- City or To	own, State
1	J	4 Donation 5 Other (Specify) Atlantic Crematory 07-29-2009 Glen Burnie, M										
once.		21. Signature of Funera	Service Lice	nsee	100111				4.			
8 01	4	Calle 1		MM	11/014						ILLITE.	
		shock, or heart fai	lure. List only	one cause on e	caused the dea each line.	th, Do not en	er the mode of dy	ing, such as cardiad	or respiratory a	arrest,		Interval Between
an	1	Immediate Cause (Fina disease or condition resulting in death)		a. Nov	isma	ilce	lecar	cinom	a of	long	_	3wocks.
cal ner		resulting in death)	•	Due to	(or as a consec	quence of):	c -1	-'0	O)	7 0 .
.	Esquentially list conditions, Due to (or as a consequence of):								? WEERO.			
T Vaminary		Esquerically list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury									7 aspolis	
	70	that initiated events resulting in death) Last		c. Due to	(or as a consec	quence of):	eracr	0,77				2.000
		d.										
Modical	ם ט											
		IF FEMALE: 23b. Was decedent pres		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death		Testania prognar	101		23d. D	ate of deliv	very	
	2	in the past 12 mon 1 ☐ Yes 2 🗷 No	ths?	4 ☐ Preg	nant at time of			icy		N.	lonth	Day Year
Dhyeician	ř	9 ☐ Unknown	-									
	2	Part II. Other significan	t conditions	contributing to d	eath but not res	sulting in the u	nderlying cause g	iven in Part I.				- 41
		1 Yes 2 No 3 Probably										
	2										Were aut	opsy findings available ompletion of cause of
Domora de la composición dela composición de la composición de la composición dela composición dela composición dela composición de la composición de la composición dela composición dela composición del composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela	5								perfe	ormed?	death?	•
Bo Comp	D	25. Was case referred to examiner?	o medical						ath (Check only	one)		
ي ا		1 Yes 2 No		1 1 1			nt 3 🗆 DOA	4 La Nursing F				ify)
	5	27. Manner of Death 1 Natural 5	Pending	(Mor	of Injury oth, Day, Year)				28d. Describe	how injury occu	ırred	
100	2	2 Accident 3 Suicide 6	investigation ☐ Could not be		ad Imbons Adda	ome form et			006 Lagation	(Ctus at an d Ni	ahan a Du	of Davids Alizabas
Cortification.	=	4 ☐ Homicide	determined	build	ing, etc. (Spec	ify)	eet, lactory, office				IDEL OF HUI	ai noule ivumber,
2	5	29a. Certifier	Certifying P	hysician: To the	e best of my kn	owledge deat	h occurred at the	time, date and place	and due to the	e cause(s) and	manner as	stated.
Modical	3			miner: On the I	asis of examin							
M	D -	29b. Signature and	certifier				29c. Licer	nse number		29d. Date sign	ed (Month	Day, Year)
,			9				Ps 7.2	14073		7.0.	28	2009.

State Registrar

DHMH 17 Rev 1/2001

2106/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. SAWHMEY

GURMEET.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] S Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 06 30 M Ruth V. Middleton Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Hospital Baltimore Agnes Saint N/AIf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Min. May 27, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2√2 F Maryland 1930 217-24-4920 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2√ No Baltimore M aryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21229 Elmridge Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11, Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2X No Specify 3 ☐Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary C. Miller William Cavey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 502 Foster Branch Road, Joppa, Maryland 21085 Charlotte A. Krueger/ Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Physician /Medical Examiner

The law requires that the death certificate be executed

certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial

funeral director,

After this

within 24 hours after death.

To the Funeral Director: A

Certification: To

P.O. Box 68760,

Records,

Division of Vital Hospital or Attending Physician:

コのト

Physician

/Medical

Examiner

10a. State

1207

Funeral

Director

28a-f show

Director

Funeral

<u>۾</u>

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, it is Modical Examiner must be rediffed at once.

altimore, Maryland 21215-0036

disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. stroke hours Due to (or as a consequence of): piratio Preumonia Due to (or as a consequence of) Hypertension

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed

Immediate Cause (Final

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee Amanda Heaston

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy 9 I Inknown

Metro Crematory, Inc.

5 Other (specify)

23d. Date of delivery Month

July 30, 2009 | Baltimore, Maryland

22. Name and Address of Facility Cremation Society of Maryland, Inc.

299 Frederick Road, Baltimore, Maryland 21228

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown

1 □Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 K No

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

25. Was case referred to medical examiner?

5 Pending investigation

28b. Time of

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

caton

28d. Describe how injury occurred

24a. Was an performed

MD

29a. Certifier (Check only 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🖪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

21229

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

0069177

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammad Valikhani 31. Date filed (Month, Day, Year)

900

State Registrar

32. Registrar's Simature JUL 3 0 2009

28a. Date of Injury (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 2^{bay} 2009 Beatrice F. C. Montague 11:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3020 Ridge Road Apt W108 Ellicott City Howard 8. Date of Birth (Month, Day, Dec 16, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington DC 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 1 F 577 52 5862 72 1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3020 Ridge Road Apt W108 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐Yes 2X No 1 ☐ Yes 2 No 3X Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Economist US Dept of Commerce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin James James Melvin Cross Margaret Celestial Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie M. Gonlin/Daughter 4963 Moonfall Way Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat'l Cem. 4 Donation 5 Dother (Specify) 8-3-2009 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Idiona Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records.

sician and burial-trans attending physician the signed by the a has certificate this certific al director, ithin 24 hours after death.

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Physician

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Physician

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Exami

Baltimore, Maryland 21215-0036

/Medical

Physician/Medical \$ Completed Be ပ Certification:

To the within 2

Registrar

29c. License number

1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

July 30, 2009

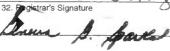
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6518 Mead

31. Date filed (Month, Day, Year)

29a. Certifier (Check only one)

JUL 29 2009



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2th 2009 Candida R. Martinez /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Glen Burnie Conter If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Vear Days Hours 1 □ M 2 X F 88 Puerto Rico 02-15-1921 Director 574-14-6308 Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2X No Director Anne Arundel Odenton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiens. Important: If item 27 Is marked other than "natural", or items 23a namy Injury or other traumatic event, the Medical Exercising Apple. United States 21113 482 Bruce Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 □ No à Specify: 3 Widowed 4 Divorced Puerto Rican White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ricarda Cordero 2 Jose Ramon Pagan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 482 Bruce Ave. Odenton, Maryland 21113 Husband Leonardo Martinez / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery07-31-2009 | Crownsville, Maryland 4 Donation 5 Dother (Specify) MD. u e o Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, brock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final seasis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NELLMAN Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician of for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 (No certificate Mama 2 **N**o 1 ☐ Yes 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Was case referred to medical examiner? 26. Place of Death (Check only one) Be 25 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death

1 Natural

2 Accident 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#10e, perFH, G893, 7, 30709, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 7:27 PM Zelda Enoch McCardell 8 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 2320 Ruth Avenue Edgemere Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Months Min Yrs 11-10-1927 MD 81 Director <u>215-24-0963</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ir than "natural", or items 23a or 28a-f show 1 Yes 2 No Director MD Baltimore Edgemere 10g Street and Number 2320 Ruth Avenue 10g. Citizen of What Country? 10f. Zip Code 21219 USA by Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev ORCE. Fannie Enoch Benjamin Enoch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William J. McCardell-Son 2320 Ruth Avenue, Edgemere, MD 21219 20c. Location - City or Town, State Date 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State 7-23-09 Owings MillsMD 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 22. Name and Address of Facility Bradley-Ashton Funeral Home Signature of Funeral Service 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Atherosclerot disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. I cate has been signed by the a page 2 should be detached it 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 MoNo 1 ☐ Yes 2 No e Hospital or Attending Physiclan; 24 hours after death. E Funeral Director: After this certifical letely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H45931 Switch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Avo Svile 203 Baltimoro MO Buten 2835 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

JUL 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #17 per Inf G895 8719709 Tr
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		Otato of Mic	,		rtificate of			Reg. N	0.2009	24422	
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_	Attending Physician: The law r death. ector: Affer this certificate has by the funeral director, page 2 s	ü	27. Manner of Death 1 X Natural	5 Pending	28a. Date of Inju (Month, Da	ıry y, Year)	28b. Time o Injury	Wor			e how in	jury occurred		
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ξ	or Al after of Direct in by	Certification:	4 ☐ Homicide	determined		ury - At non c. <i>(Specify)</i>	ne, rarm, str	eet, factory, office		City or T	own, St	and Number or Ru ate)	rai Houte Number,	
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DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma	-	epartmer Certifica			ind M	F	Reg. No.	09	24423
di	Physici /Medic		1. Decedent's Name (First, Middle, Last) Donald Miller							2. Date of Dea Month July 1	9, 2009		3. Time of Death 10:14 AM
1	Examin	er	4a. Facility Name (If not institution, give s 88 Wimert Avenue			,	Town, or mins	Location o	I Death		4c. Count	y of Death roll	
2.45	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birtho	fay) If Unde	r 1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Sept /	h	9. Birth	place (State or Foreign ntry) Land
	within 72 hours after death with the Maryland ane. ane. than "reture!", or items 23e or 28e-1 show he Medical Examiratination confilled at	rector	Usual Residence of Decedent	10c. City, Town or Location Westminster 10f. Zip Code						10g. Citizen of What 0			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show amy injury or other treumatic event, the Medical Enarthment must be notified at ance.	Completed by Funeral Director	11. Marital Status 1 1 ↑ Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give A Year or Dates:		13. Was Dece II Yes, spe 1 Yes	city Cuba	ispanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	Bla	ce - Americk, White	
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Mary	nd 2 shoulth and N 27 ie mar r treumat		19a. Informant's Name/Relationship (Type Ken Miller/brothe					and Numbe	r or Rura		ar, City or Town	, State, Zi	o Code)
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	Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Sause (Final disease or condition	e cause on each lin	the death. Do not	enter the mo	de ol dyin	g, such as	cardiac o	r respiratory ar		250	Approximate Interval Between Onset and Death
1760,	res that the death certificate be executed by the ettending physicien and be detached for use as the burial-transit	ledical Examiner	d										
P.O. Box	Attending Physicien: The law requires that the death certifica closal. cro	by Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day Year		•
ords, P	w requires that been signed b should be deta	ted by PI								/ _			
Vital Records,	n: The law r licete has be r. page 2 sh	Completed							_	autop perfo 1 Tyes	rmed? 202 No	prior to co death?	ompletion of cause of
₹	/sicial s certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	nt 2 ER/Outpa	atient 3 🗆 D	Ectopic pregnancy Other (specify) Describe and Death Check only one) 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 24d. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death Check only one) 27d. Place of Death Check only one) 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred						
Division of	or Attending Physician: The lav later destors. After this certificete has Director: After this certificete has in by the funeral director, page 2	atlon: T	27. Manne of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injun (Month, Day	/ 28b. Tim	ne of	28c. İnjun Worl	y at k?					
Divis	ital or Atturs after de rai Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, larm (Specify)	, street, facto	y, office			281. Location (S City or Tox	Street and Num wn, State)	ber or Ru	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edlcal	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of er: On the basis of and manner stat	examination and/o	death occurred or investigation	at the tim	ne, date an pinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)
	To the within To the comple	×	29b. Signature and title of contifier	m		29	c. Licens	e number	1 /4		29d. Date sign	ed (Month	, Day, Year)
			Wellert.	1 K	en		D3	429	18		July	25	,2001
			30. Name and address of person who con	impleted captise of de	ath (Item 23a) (Ty		10 St	e C	1.	1extu	ninch	er	MD 21157
÷	Sta Registr		31. Date liled (Month, Day, Year) JUL 2 9 2009	32. Registra	r's Signature	ales	1			- 01	01		110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4h. City Town, or Location of Death 4c. County of Death Examiner Hospice of Northwest 16 Ratimore eason's ndallstown Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Min -28-0499 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, it is Mudical Exarcing must be notified at Director 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No Specify ģ 3 Widowed 4 Divorced BACK Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retir<u>e</u>d) Elementary/Secondary (0-12) College (1-4or 5+) ouse wife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be onia ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Owngs Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cometey 08-01-2009 Woodlawn, MD injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee hac Greene funeral six . Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conse dence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each of cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) physician Physician/Medical as attending IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy for 1 in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏂 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate Division of Vital 2 🗆 No 1 □Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 🛂 Ño Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print; MO Macon 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

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		For State Registrar	State of M		d / Depa		lealth an	d Mental Hy		9 24425	
Physicia /Medic		Decedent's Name (First, Middle James Thomas						2. Date of De Month	ath Day Yea	3. Time of Death	
Examin		4a. Facility Name (If not institution, Saint Josep	-		ter	4b. City, Town, or		eath VSON	4c. County of De		
Funeral Director		5. Social Security Number 217-24-5376 Usual Residence of Decedent	6. Sex 7. Ag 1 X M 2 □ F	je (In yrs. la 79	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da June 2	y, Year) , 1930 Ma	Irthplace (State or Foreign Country) ryland	
Maryland -f show lied at	tor	10a. State MD Baltin	nore		Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2√☐ No	
h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 2909 Coldstream	n Way #D			10f. Zip Code 212	34		10g. Citizen of What G	Country?	
filed within 72 hours after death with the Maryland Hygiene. Hygiene with "natural", or items 23a or 28a-f show ent, the madical Examination at the natified at	à	11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ed 1 Yes 2 Yes Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 🕅 No	ispanic Origin' n, Mexican, Pi Specify:	? (Specify Yes or No uerto Rican, etc.)	- 14. Race - Ar Black, Wh	nerican Indian, ite, etc. white	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natur any Injury or other traumatic event, the Madical Once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	s Education t grade completed) College (1-4or 5	5+)	(Give life. L	dent's Usual Occup kind of work done o DO NOT use retired Lip build	furing most of)	working	16b. Kind of Busines	s/Industry unk	
tould be file I Mental Hy narked oth	To Be	17. Father's Name (First, Middle, L Charles O'Hare					F1or	Name (First, Middle,	yn Byrne		
t and 2 sh Health and em 27 is n	. 7	19a. Informant's Name/Relationsh Ruth O'Hare/s 20a. Method of Disposition		20h Pis	2909			r Rural Route Numb r #D Balti Date	more, MD 20c. Location - City of	21234	
it. Pages intment of intant: If its injury or o		1 ☐ Burial 2 ☐ Cremation 4 🗓 Donation 5 ☐ Other (Sp	ecify)	се	metery, cren	natory or other plac					
Department of the position of		21. Signature of Funeral Service L Ronald S	201/1 V	1	Ba	altimore.	MD 21	201	Baltimore	Approximate	
Physician /Medical		23a. Part 1 Enter the disease, or shock or heart failure. List of Immediate see (Final disease or condition resulting in death)	a. SUDDE	NLDE	ATH	or allo mode or dym	9, 00017 00 001	alao or respiratory a		Interval Between Onset and Death	
Examiner	er	Sequentially list conditions,	b. CARDI	AC A	RREST						
	Examiner	Sequentially list conditions, if any, leading to instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. OTHER Due to (or as			9					
tificate be ng physicia as the bur	edical		d. FERIP	HERA	L VAS	CULAR D	ISEAS	gende Sede Bedee			
requires that the death certificate seen signed by the attending physi hould be detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown							23d. Date of o Month	lelivery Day Year	
res the signe	Š	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. THROMBOCYTOSIS CHRONIC OBSTRUCTIVE LUNG DISEASE							23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
The law ate has b	Completed		TROCTIVE D		DISEA			1 □ Yes	prior t rmed? death' 2 □ No 1 □ Ye		
Physicia this certi	: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie		R/Outpatier	othe	er: 4 🗆 Nursir		dence 6 ☐ Other (Sp	pecify)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investige 3 Suicide 6 Could not determine	(Month, Da	ıy, Year)	Injury	Work	γaι ? Yes 2□No		Street and Number or	Rural Route Number,	
To the Hospital or within 24 hours afte To the Funeral Dir.		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best examiner: On the basis of	of my know	rledge, death	n occurred at the tir	ne, date and p	lace, and due to the	cause(s) and manner	as stated.	
To the I	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. License			29d. Date signed (Mo		
	+	30. Name and address of person w	vho completed cause of d	eath (Item :	23a) (Type,		146595	j	1/20	1107	
Stat		31. Date filed (Mohih, Day, Year)	the same	ar's Signatu	LADI		RD SUI	TE 106	ROSEDALE,	MD 21237	
Registra		JUL 29 20	UJ Charles	14.	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 7:32 am Jus thni e 2009 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Summi If Under 24 Hrs. 8. Date of Birth
Min. (Month, Day, Year) If Under 1 5. Social Security Number Year Days Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1□M 2XF 8-54-5899 Director KTOBER Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Pres 2 □ No Directo my BAITIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UISIA or items 23s 2/220 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 PNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes X No Specify: Specify: BIALK 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Howse Cleaning None omest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ! ပ AWYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health are Important; if item 27 is any injury or other trausping. 402 erner Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Han Com Wodlawami 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Betts Funeam 1129 N. CAROLINEST BAITO. MO. 215/3 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Me lo de sonsequence **Physician** years DIUSH /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☑ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Known 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the ft investigation 2 Accident 6 Could not be determined 3 🗆 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshalee Dr. Elkvidge Md. 21075 Jenni

DHMH 17 Rev 1/2001

State

Registrar

oven 31. Date filed (Month, Day, Year)

JUL 3 0 2000

parked

32 Registra 's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Wilbur Ouinter 2009 4:30 Α July 25, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Riverview Care Center Essex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1**⊠**M 2□F Months Days Hours 220-01-3620 92 **Director** 8-2-1916 PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 XYes 2 No Baltimore Dundalk MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ò 6800 Martin Avenue 21222 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [¾Yes 2 □ No If Yes, Give Year or Dates: WWII or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify. þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If them 27 is marked other the any Injury or other traumatic event, the I once. Steel Worker Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ivan C. Quinter Laura Anderson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3106 Dunglow Road, Dundalk, MD 21222 Nancy Gibault - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-27-09 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature di Eune 22. Name and Address of Facility Bradley-Ashton FUneral Home PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed HYPERTENSION sician and burial-tran Due to (or as a consequence of): Box 68760 attending physician for use as the buria DEMENTIA Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>≨</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has certificate 1 □Yes 2 of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Universing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation within 24 hours ar er dearh.

To the Funeral Director A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident a er death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7-27-09 2 Market Place Dundale mg 21222 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 18 per fh g893 7-30-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 24428 Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Idahlia Siegel Rogers July 28 2009 9:40 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 12 1929 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ M 2 🔽 F Yrs. 79 MD 218-26-2914 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No **Baltimore Timonium** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 15 Walton Way USA 21093 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 12 5+18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Rectenwaw Rectenwald Gustav Siegel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Rogers Mueller/daughter 8 Tenby Ct., Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Denation Other (Specify) Atlantic Crematory 7/30/09 Glen Burnie, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 yăŋ 23a. Part 1. Enter the disease or complications that Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, used the Immediate Cause (Final disease or conditi n resulting in death) ENTIA ARKINSONS DISEASE Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

g physician and is the burial-trans

that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

the Hospital or Attending Physician:

within 24 hours arter committee for the Funeral Director: Aft To the Funeral Director: Aft To the Funeral Filled in by the funeral Funeral Filled in Funeral F

Physician

/Medical

Director

Funeral

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Completed

Be

10a. State

MD

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If then 27 is a marked other than "hatural", or Items 23a or 28a-f show any injury or other traumatic event, Its Maryland Examinan Items Iber Incillied at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Physician/Medical

23b. Was decedent pregnant

9 Unknown

in the past 12 months?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical

31. Date filed (Month, Day, Year) JUL 29 2009

5 Pending

investigation 6 ☐ Could not be

determined

1 Yes 2 No

examiner?

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a, Certifier

4 Homicide

IF FEMALE:

\$

Completed

Be

Certification: To

Medical

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

performed? 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

HOSPICE

1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌠 Unknown

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the course of the cour

(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a

D64395

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad

> Danielle Doberman, M.D.

555 W. Towsontown Blvd., Towson, MD 21204 32. Registrar's Signatur

Registrar

DHMH 17 Rev 1/2001

10 V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 26, 2009 Sr. M. Madeline Roddenbery, R.S.M. July 11:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore The Villa 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 7-3-1917 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🖺 F 215-56-5402 92 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f sho 1 ☐ Yes 2 XNo Director Baltimore Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6806 Bellona Avenue 21212 USA Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ X o Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Supervisor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 Is marked ott Be John W. Roddenbery Mary Carle Hurst 19a. Informant's Name/Relationship (Type. Print) Religious 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sisters of Mercy-Order 101 Mercy Drive, Belmont, NC 28012-2898 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery: 7-29-09 Woodlawn, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bradley-Ashton FUneral Home PA, 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final A therosoloropic Physician 20 YUS disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlahran lift completely filled in by the funeral director, page 2 should be detached for use as the burlahran lift. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 Tyes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Ño 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 031805 mian-0

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) JUL 29 2009

206

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Beltmare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible/22/09
Amend #25 per ME g893 8/5/09 TT Amend #5 per rep. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** M2:54AM AIDE 26 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner BUILDING Trauma If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1**301<u>a1.322111</u>28887**91 05-4-3.44-0503 7. Age (In yrs. last birthday) Funeral Year Min. Months Days Hours 1 □ M 2 🔼 F New York Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Product Examinor must be rediffed at ty Yes 2 □ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 O writer freelance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental tem 27 is marked o John Chappel Crawley Ellen Montgomery ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 532 S. Melville Street Philadelphia, PA 19143 Sally Williams/niece Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility
STate Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wang Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faildire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ubdural **Physician** 14 hours /Medical Due to (or as a consequence of) Examiner 14 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit CERTIFICATION APPROVED BY MEDICAL EXAMINES Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 - Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 X es 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) spital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 No 10 1 ☐ Yes 2 Accident 12noon 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Mome To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Baltimore 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

State Registrar llism

31. Date filed (Month, Day, Year)

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Greenest.

225.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shock Trauma Center

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 12:58 AM William 26 0.7 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6Len Burnie Anne Arundel Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □XM 2 □ F 50 **Director** 013-52-3683 Massachusetts Feb 9, 1959 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Odenton Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21113 2108 Peaceful Way #302 by Funeral death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite any or other traumatic event, I'ls Medical Experimenty or other traumatic event, I'ls Medical Experimenty 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Supply Credit Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Donahue 2 William John Sciascia, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2108 Peaceful Way #302 Odenton, Maryland 21113 Nancy Jean Sciascia/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 7/30/2009 Odenton, Maryland 21. Sign of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 10000 M00957 unnita R 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Emphysema 2 hars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) P.O. Box 68760, physiciar Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) To the Hospital or Autenauss.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached formula for the funeral director. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 🗷 No 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number TOMAN, MID. D0061331 JULY, 28, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neel Vibhakar, M.D. 301 Hospital Drive. Glen Burnie, Maryland 21061 31. Date filed (Month, Day, Year) 82. Registrar's Signature State JUL 29 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Physicia		egistrar . Decedent's Name (First, Middle,Last)				2. Date of De Month		3. Time of Death 1445 hrs		
edical Exami	ner	Thomas Henry S	Month July 26, 2	2009 4c. County of [
		a. Facility Name (if not institution, give	street and number)	1 .	4b. City, Town, or Location of Death Laurel			Anne Arundel		
		3565 Ft. Meade Road	x 7. Age (in yrs. la			24Hrs. 8. Date of E	Birth(MM/DD/YYYY)	3. Birthplace (State or		
Funeral Director	- 1	5. Social Security Number 6. Sec	(M 2 F 6	Month		Min	16, 1949	oreign Country) Texas		
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any		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits 1 Yes 2 X No		
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th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number		10f. Zi	o Code		10g. Citizen of Wha	t Country?		
the M n or 2 tified	ä	3565 Fort Meade	Road, #219		20724			SA Black		
with ns 23.	교	11. Marital Status	12. Was Decedent Ever in U.	S. 13. Was Deced	ent of Hispanic Orig ify Cuban, Mexican	gin? (Specify Yes or I , Puerto Rican, etc.)	No- 14. Race - White,	American Indian, Black, etc.		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygers team 77 is marked nother than "natural", or items 23a nor 28a-f she trannante event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married	1 Yes 2 X No		No specify:		Specify:	White		
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36 nin 72 than '	ompleted	12th	4	Computer	Consulta	nt		r Services		
d with	녌	17. Father's Name (First, Middle, Last))	's Name (First, Middl	e, Maiden Surname)					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Richard Arthur			Nin	a Bryan	Number City of Town	State Zin Code)		
21 nould d Mes is ma	유	19a. Informant's Name/Relationship (T	Number, City or Town, State, Zip Code) On , TX 77025							
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importanti: If tien 27 is marked other than injury or other traumatic event, the Medical.		William M. Salath	niel/Brother	Place of Disposition (N		ne, Housto Date	20c. Location -	City or Town, State		
Sre, sslar of Hea If ite		1 Burial 2 X Cremation 3	Removal from State	crematory or other plac	e)	July 29,		on, MD		
imore Pages ment of H taut: If i		4 Donation 5 Other Specify		st Arundel	Crem. nd Address of Facili	2009		1 Home, P.A.		
Baltimore, permit. Pages I at Department of Hee Important: If ite	1	21, Signature of Funeral Service Licer	2 20 JA011	02 212 1	ralbott A	Tania Ta	aurel. MD	20707		
	-	23a. Part I. Enter the disease, or comparing List only one cause on e	plicate ns that caused the death	n. Do not enter the mod	e of dying, such as	cardiac or respiratory	arrest, shock, or hea	Approximate Interval		
Physiciar Medica			Atherosolerotic Cardio	ntoxication	cardio	vascular d	lisease	Death		
camine	1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence							
		Sequentially list conditions.	·							
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	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):						
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y be execian a	Medical	UNPENDED	23d. Date of	delivery						
tox 68760, eath certificate be executed a attending physician and for use as the burial - transit	Me	IF FEMALE: 23b. Was decedent pregnant in the	Month	Day Year						
Box 687 Heath certific The attending p	sician/I	past 12 months?	1 Live birth 4 Pregnant at time of o	2 Fetal death 5 Other (5		pic pregnancy	_			
Box death he atte	VSi	1 Yes 2 No 9 Unknow	J Gillanouni	230	Did tobacco use cont	ibute to the cause of death?				
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Division of Vital Records, P.O. tal or stending Physician: The law requires that the safter death. In Director: After this certificate has been signed by all Director: After this certificate has been shown by the stand	Be C		Marian -		Other	th (Check only one)	Posidence 6	✓ Other: Scene		
Vita hysical	TO B	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA 28c. Injury at W	Nursing Home	cribe how injury occur			
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ivis after Dire	Certification:	3 Suicide 6 X Could no determin	ot be Passad	residence		Laur	el, MD	rt. Meaue ku		
Division Hospital or Attend 24 hours after death	ة ا		and the state of t	adaa daath occurred s	t the time, date and	place, and due to the	e cause(s) and manne	er as stated.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and	Completely	(Check only 1 Certifying Physical Control one) 2 Windows Medical Examination	ner:On the basis of examination	and/or investigation, i	n my opinion, death	occurred at the time,	, date and place, and	due to the cause(s)		
To the within	Mos Po	29b. Signature and title of certifier	and manner stated.		29c. License numb	per	_ ·	ned (Month, Day, Year)		
	1	him his	, no		O.C.M.E.		July 27, 2	009		
		30. Name and address of person wh	no completed cause of death (It	em 23a)						
(o V		Ling Li, MD Assistant	Medical Examiner 1	11 Penn Street, E	altimore, MD 2	1201				
<u> </u>	Stat	at B t Stad Ot 11 Day Varel	32. Registrar's Sign	nature						
Reg	istra	JUL 292	009 Three	1 grack			(Name)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 11,12,15,17-19a-20c, 22 per fh 8898 12-15-09 vt Amend Item 5 per fh,8908,10/08/2010 Health and Mental Hygiene 11,12,15,17-19a-20c, 22 per fh 9898 12-15-09 vt Amend Item 5 per fh,8908,10/08/2010 Control County (Control County)

1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 July 16, **Physician** 2:56 PMM James Garland Smith Jr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie 1 Bertram Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number unk 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Months 1**X**] M 2□ F 220-36-0695 66 July 18, 1942 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No MD Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 Bertram Drive or items 23a 21060 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. unle 11. Marital Status 1 Yes 2 No unk
If Yes, Give
Year or Dates: 1964–66 1 Never Married 2 Married unkBaltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 Divorced 'natural' 16a. Decedent's Usual Occupation
(Give kind of work done during most of working unk
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Complet d 2 should be filed within 7/ in and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) unk. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be unk Garland Smith, Sr. ပ James Elsie Mae Rayfield Depertment of Health and I happertment of Health and I important: If Item 27 is maenty injury or other traumat one. 19a. Informant's Name/Relationship (Type, Print)
Suzzanne W. Austin/ Sister in law 47417 Pinewood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MI. 48051 Dr. Chesterfield, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 11-5-09 Beltsville, Md. 4 □ Donation 5 ₩ Other (Specify) Chesapeake Crem. 22. Name and Address Gafa/Stephen 7. Lohrmann PA. State Anatomy Board 655 W. Baltimore Street 21. Signature of Euroral Service Licensee Ronald S, Wade Board 655 8 21201 21286 State Anatomy Baltimore, MD 21201 21286

25a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** teriosclerot /Medical Due to (or as a consequence of): Examiner TY pertension Pour to Confes a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. φ cate hes been sign, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 certificate hes 1 Yes After this certifice funeral director, § 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: Hospital or Attending 1 Natural Injury 5 Pending death. 1 Tes 2 No 2 Accident investigation Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 609 DW 85 on s 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JUL 29 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 23aPtI,II,25 per me, 8893,07/30/09dhb
Reg, No.
Reg, No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** WILLLAM , 200° /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYVIEW MEDICAL CENTER BALTIMO
6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. BALTIMORE CITY JOHNS HOPKINS 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex ^t 1 M 2 □ F 8. Date of Birth (Month, Day, MAY 21, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs. KEŇŤŰČKY 57 219-54-3967 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🛛 No Director MARYLAND BALTIMORE COUNTY HALETHORPE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2814 MICHIGAN AVE. 21227 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1971 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced WHITE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DIRECTOR OF FINANCE STATE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NOAH CRUM HELEN G. MARSH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY R. TURNER / WIFE 2814 MICHIGAN AVE., BALTIMORE, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition JULY 30 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MEADOWRIDGE MEM. PK. 2009 4 □ Denation 5 □ Other (Specify) ELKRIDGE, MARYLAND e of Fun al Servi 21. Signat KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial Hemorrho /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ON APPROVED BY MEDICAL EXAMINER law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, CERTIFICAT Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò Coagulopathy, Non-Alcoholic Steatohepatitis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1**K**iYes 2X(No Medical Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 4 hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a To the Funeral C 1xCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JULY 24, 2009 RES-000 30. Name address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE, BALTIMORE MD 21224 ASNER 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Ma	iryland / l		rtment of F tificate of I	lealth and M D <i>eath</i>	_	giene Reg. No. 🤈 🗍	ng	21.1.35
			Decedent's Name (First, Middle, L.)	.ast)					2. Date of Dea	ath	Voor	3. Time of Death
	Physicia /Medic		Matsue	Kawas	sugi		Truff	er	Month July	28 2009	Year	9:29A M
	Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town, or	Location of Death		4c. County	of Death	
, w			Tate Hospice				Linthic				Arun	
h	Funeral Director		5. Social Security Number 6. 217-38-8645	Sex 7. Age 7. 2 → 7. 2 → 7.	e (In yrs. last bii 2	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Jan. 5	y, Year)	9. Birthp Coun Japa	lace (State or Foreign try) N
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loc	eation				1	0d. Inside City Limits
	e Maryle la-f sho	Director		Arundel	Pasade		attori					1 □Yes 2 ☑No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Coun	try?
	ath wi		7698 Briar Lar	ie .			21122			USA		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Macient Examinating has notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1			Vas Decedent of H Yes, specify Cuba ☐Yes 2☑No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Rac Blac Specify	e - Americ ck, White, e	
215-0036	thin 72 hor ne. nan "natur. Medical J	Completed	15. Decedent's (Specify only highest g	Education grade completed) College (1-4or 5-		(Give	ent's Usual Occup kind of work done o OO NOT use retired	during most of work	ing	16b. Kind of Bu	usiness/Ind	dustry
7	ed wil ygien ygien ier th	Co	12			Seam	stress				rnati	on
<u> </u>	be file	Be	17. Father's Name (First, Middle, Las	st)				18. Mother's Name		Maiden Surnan	10)	
<u>Ş</u>	ould Mer narke	ဥ	unknown		T				known			
Maryland	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship				,	and Number or Rur			State, Zip	Code)
a) —	1 and Heali em 2		Christopher Tr 20a. Method of Disposition	rutter so			Cloister sition (Name of patory or other place	Rd. Arno	1d MD 2	1012 20c. Location -	City or To	wn, State
0	9		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1		natory`or other plac matory I:		/09		·	Maryland
	permit. Pag Department Important: I any Injury c	Ÿ	21. Signature of Funeral Service				. Name and Addre			Funera		
ñ	any per		I de de	Ther !			3111 M	ountain R				
			23a. Part 1. Enter the dispase, or co shock, or heart failure. List on	mplications that caused	the death. Do	not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, one out of the	~9	(0	meer				10	Onset and Death
	/Medical		resulting in death)	Due to (or as a	a cons+ uence							-8
	Examiner	_	Sequentially list conditions,	b	- 47							
0 .	pe tis	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	Due to (or as a	a consequence	of):						
30	and and al-tran	Examiner	that initiated events resulting in death) Last	c	a consequence	of):					-	
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βg	ificate g phy as the	edical		d								
O. B0X	death cer e attendin d for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 1 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnanc Other (specify) _	у			te of delive	ery Day Year
rds, P.	requires that the reen signed by th nould be detache	þ	Part II. Other significant conditions	contributing to death bu	it not resulting i	n the un	derlying cause giv	en in Part I.	23e. Did t			ne cause of death?
Hecords	ding Physician: The law red.h. After this certificate has bee funeral director, page 2 shot	Completed							24a. Was autor perfo	osy rmed?	Were auto prior to co death? 1 ∐Yes	psy findings available mpletion of cause of
	sian: ertifica ctor, p	Be	25. Was case referred to medical examiner?					26. Place of Deat			100	
01 0	Physician: r this certific ral director,	၉	1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatien	t 3 DOA Oth	er: 4 🗆 Nursing Ho	me 5 ☐ Resi	dence 6 Oth	ner (Specif	Hospe House
	ing P		27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Injur Worl	(?	28d. Describe	how injury occur	red	, ,
<u>s</u>	ttend death tor: /	cati	2 Accident investigati 3 Suicide 6 Could not	he				Yes 2□No	004 1	O		ID. O. M. O. L.
UIVISION	al or Attending F s after death. I Director: After d in by the funer	Certification:	4 ☐ Homicide determine	28e. Place of Inju building, etc	. (Specify)	im, sire	et, factory, onice		City or To	vn, State)	er or Hura	i Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical C	29a. Certifier (Check only one) Certifying I	Physician: To the best of aminer: On the basis of and manner sta	examination a	e, death	occurred at the tile estigation, in my co	me, date and place, pinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as s and due to	stated. o the cause(s)
	To th within To th сопр	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
			Mana	on M.I	>		D3	9505		July:	29,	2009
	6		30. Name and address of person wh	arkan 3		(Type, F	of tal D	9505 v. Glev	Bur	nie, r	1D.	21061
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	1	a. al. I					

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TTE#5perFH, G894,8/12/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No._ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 26, Trach 2009 Helen July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 5, 1 7. Age (In vrs. last birthday **Funeral** 180-50-9553 Days Hours Months 1 □ M 2 🗓 F Yrs 88 Sept. 1920 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at Directo Westmoreland Belle Vernon PA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 23a or U.S.A. 15012 Funeral 370 Pear Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the filed within and Mental Hygiene. Then of Health and Mental Hygiene. Ant: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify. 2 Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa (Unknown) ၉ Franciszek Ciak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stefan O. Trach (Son) 3 Marcia Ct., Rockville, MD 20851 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages
Department of
Important: If It
any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Dopation 5 □ Other (Specify) Grandview Cemetery 7/31/09 Monessen, PA 21. Signature of Funeral Service License 22. Name and Address of Facility Dalfonso-Billick Funeral 441 Reed Ave., Monessen, Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of) Examiner Chronic Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 █ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Anemia, Renal Failure Be Completed 24a. Was an autopsy performed? yes 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending within 24 hours after deam.

To the Funeral Director: / 2 Accident investigation

23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐Yes 2 ☐No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) July 26, 2009 Doo60117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd., Bethesda, MD 20814 32r Registrar's Signature **ORIGINAL**

Year

6:10

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 21 No

Poland

White

 A^{M}

Registrar DHMH 17 Rev 1/2001

the Hospital

Tot

3 Suicide

29a. Certifier

Medical

State

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Eric J. Park, MD

6 Could not be determined

JUL 29 2009

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Physician /Medical Examiner

Mary Bessie Vaughn

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Social Security Number Age (In vrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 🛛 F 214-54-7973 64 Director April Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience must be notified at Director MD Howard Elkridge 10e. Street and Number 10f. Zip Code 6305 Virginia Pine Place, Apt.102 21075 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2√∑XNo Specify. à 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Custodial Tech. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rufus Dillard Martha Lovegrove ဂ 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Vaughn Kluge/ Daughter 203 Greenview Ave., Reisterstown, MD 21136 Date 29 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem.Park 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee J. Ken Stile M01053 313 Talbott Ave., Laurel, MD 20707 23a. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 0250 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) ivision of Vital Records, P.O. Box 68760, ted by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 🛂 No 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an has 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No 2 ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 31. Date filed (Month, Day, Year) 32. Registrar's Signature

 Birthplace (State or Foreign Country) 30,1945 T'N 10d Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. white Specify: 16b. Kind of Business/Industry Maintenance 20c. Location - City or Town, State Dorsey, MD Approximate Interval Between Onset and Death discose 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

3. Time of Death

2009

57 am

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend #30 & 31 per DVR g893 7/30/09 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** ROE UL 200 6:16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a 1204 Harwood Ave. Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min 1 XM 2□ F 218-01-5249 VA. Director 96 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f show any or other transmit or other transmit or other transmits event, in Medical Exprint. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√2 Yes 2 No Director MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 USA 1204 Harwood Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer Bethlehem Steel Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nannie Hicks Flovd Venable ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Gabbin (grandchild) 1204 Harwood Ave. Balto, Md. 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott Burial 2 Cremation 3 Removal from State Arbutus Mem. Pk. July 31,2009 Baltimore, Md. Monation 5 ☐ Other (Specify) 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home Signature of Funeral Service Licensee 1412 F. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that cau so the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC OBSTRUCTIVE DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inintediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed NOREXI 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy performed) 1 🗆 Yes 2 🔼 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Patter death.
Director: After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral the Hospital to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continue of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-23-00 D0058735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

riangle 827 Linden Ave Baltimore, MD 21201

GAWA

JUL 29 12009

31. Date filed (Month, Day, Year)

ALL

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		I- For State Registrar	Ce	rtificate of	Death	_	Reg.	No. 4 U	
Physicia		Decedent's Name (First, Middle, La	ist)				Date of Death Month Date	av Year	3. Time of Death
edical Examir		Douglas	Woods Sr.				July 26, 2009		1748 hrs
		4a. Facility Name (if not institution, g		4		Location of Death	1	4c. County of Deat Anne Arunde	
		Baltimore Washington M			Glen Burnie		To Date of Black (MM/DD/YYYY) 9. Bi	
Funeral			Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Day			Forei	ign
Director		219-38-4737	X M 2 F	66 Yrs.	, , ,		03/20/	1943	ountry) MD
		Usual Residence of Decedent	110- 6%	y, Town or Locati					10d. Inside City Limits
w any		10a. State 10b. County		y, rown or Locali	on				1 Yes 2 X No
Maryland 28a-f show	į		Arundel		1400 77 0 44	Severn	100	Citizen of What Co	untry?
Mary Mary	Director	10e. Street and Number	2 3		10f. Zip Code	21144	109.	US.	
ith the Maryland 23a or 28a-f sho		8110 Telegraph 1		"T		21144			erican Indian, Black,
cms the	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U Armed Forces?			spanic Origin? (S n, Mexican, Puerto		White, etc.	mean meian, black,
or dea	Fu		1 Yes 2 No	1	Yes 2 No	specify:		Specify: W	hite
rs afb ural" mine	à	Widowed 4 X Divorce Decedent's Education (Specify)	or Dates:		X-	tion (Give kind of	work done	6b. Kind of Business	s/Industry
2 hou "nat	ĘĘ.	Elementary/Secondary (0-12)	College (1-4 or 5+)			e. DO NDT use ref			
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5-00 led wit Hygien other the Me	Completed	17. Father's Name (First, Middle, La	st)			18.Mother's Nam	e (First, Middle, Mai	den Surname)	
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat c event, the Medical Exa	Be	James Wo	oods			Mildre		Miles	
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other that natic event, the Med		19a. Informant's Name/Relationship						er, City or Town, Sta	te, Zip Code)
e, MD 2 1 and 2 shou Health and M item 27 is n		Tracey Sheffield				-	sadena, M		Taura State
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 X Burial 2 Cremation	_	. Place of Dispos crematory or oth		Jı	uly 31	20c. Location - City of	Ji Town, State
MOFE Pages 1 tent of E ant: If i		4 Donation 5 Other Speci	Me	eadowrid	ge Cemet	ery	2009	Elkridge,	Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite	-1	21. Signature of Funeral Service Lic		22. N	lame and Addres	s of Facility	Stallings	Funeral	Home, P.A.
ದ ಕಲ್ಕಟ್		23a. Part I. Enter the disease, or co	Stallens	1)	3111 Moi				21122
Physician		23a. Part I. Enter the disease, or contailure. List only one cause on	iplications that caused the deal each line.	HTDo not enter ti	ne mode of dying	, such as cardiac	or respiratory arrest	, snock, or neart	Approximate Interval Between Onset and
/Medical caminer	ì		a Hypertensive		cleroti	c cardio	vascular	disease	Death
		or condition resulting in death)	Due to (or as a consequence	of):					!
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):					
-	튑	cause. Enter Underlying Cause (Disease or injury that initiated	c						
ransit and Ben	Examiner	events resulting in death) Last	Due to (or as a consequence	of):					
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760, icate be e	Medical							23d. Date of delive	env
876 iffcat ng phy		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre	-	etal death 3	Ectopic pregr	nancy	Month	Day Year
Box 68' e death certifi	Physician	past 12 months?	4 Pregnant at time of	J 4L	her (Specify)				
Box e death of the attented for us	hys	1 Yes 2 No 9 Unkno	9 OIIKIIOWII				les suit		to the course of death?
s, P.O. B ires that the de signed by the	by P	Part II. Other significant condition	s contributing to death but not	t resulting in the t	underlying cause	given in Part I.			to the cause of death?
S, P									autopsy findings available
Records, The law require	Completed						24a. Was ar autopsy	prior t	to completion of cause of
Recol The law icate has	mo						perform 1 ✓ Yes 2		
ital Recionant The scertificate rector, page	o	25. Was case referred to medical			26.Plac	ce of Death (Chec	k only one)		
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Divi	Certification:	4 Homicide determi	(0,000))						
e Hos 124 h e Fun letely		29a. Certifier 1 Certifying Phys	sician: To the best of my knowle ner:On the basis of examination	edge, death occu	rred at the time,	date and place, ar	nd due to the cause	(s) and manner as s	tated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. Irransi	Medical		ner: On the basis of examination and manner stated.	anu/or investiga				29d. Date signed (/	
	Σ	29b. Signature and title of certifier				nse number		,	vioritri, Day, rear)
		NUM	-1~		0.0	.M.E.		July 27, 2009	
1		30. Name and address of person w			1 Dann Stran	et, Baltimore,	MD 21201		
		Donna M. Vincenti, MD	Assistant Medical Exa			a, Daiuliloie,	1VID 2 1201		
St	ate		32. Registrar's Sign	gare					

ORIGINAL

			For State Registrar	State of Marylan		rtment of F tificate of		Mental Hy	giene Reg. No. 2	000	2
ı	Physici	an	Decedent's Name (First, Middle, Last	Robert Woolwi	ne			2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City. Town, o	r Location of Deat	July 2		09 ounty of Death	7:45 P [™]
	Examili	iei	3318 Elm Avenue			Baltim				N/A	
ĺ.	Funeral Director			ex 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di Oct 3	th ay, Yea <i>r)</i> 1943	9. Birthp Cour MD	place (State or Foreign htry)
	and bw		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				1	0d. Inside City Limits
	Mary a-f she	tor	MD N/A			Bal	timore				XX Yes 2 No
	3a or 28a	al Director	10e. Street and Number 3318 Elm Avenue			10f. Zip Code	21211		_	of What Cour	itry?
036	I within 72 hours after death with the Maryland ijene. I than "natural", or items 23a or 28a-f show The Mcdical Examination to the Intiffied at	by Funeral	11. Marital Status 1 ☐ Never Married	12. Was Decedent Ever in U.S Armed Forces? 1 \(\text{Yes} \) 25 No If Yes, Give Year or Dates:	l1	Vas Decedent of F f Yes, specify Cuba	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - Americ Black, White, o	
2-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	pation during most of wor	king	16b. Kind	of Business/Ind	dustry
7 7	within iene. than than	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired Cleaner				Constr	ruction
		Be	17. Father's Name (First, Middle, Last)	Dean Estle W	oolwin	ne l	18. Mother's Nar	ne (First, Middle ie Mae I			
ar y	should ind Me imark umartic	은	19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailin	g Address (Street					Code)
, Ma	and 2 eaith a n 27 Is		Elaine Woolwine (Wife)	3318	Elm Ave	nue Ba	lto, MD	2121	1	
Hore	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other important: If item 27 Is marked other any injury or other traumatic event, once.		20a. Method of Disposition 1 XX urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	removal from State T =		sition (Name of natory or other place Park Ceme		Date 1/09		ion - City or To imore,	
ранишо	permit. Departr Importa any inju		21. Signature of Fundfal Service Liben	9667		Name and Addre		Funera]	Home	Inc.	
- F	Physician		23a. Part 1. Ent. r the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications hat caused the death one cause on each line.	. Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory a	nrrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ		7,000	oren I				2 2093
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:	e Hospit 124 hours e Funera letely fille	Medical C	29a. Certifier 1 Certifying Phyone 2 Medical Exam	ysician: To the best of my know iner: On the basis of examinat and manner stated.	vledge, death ion and/or inv	occurred at the tirestigation, in my o	me, date and place ppinion, death occu	e, and due to the irred at the time,	cause(s) ar date and pla	nd manner as s ace, and due to	tated. the cause(s)
	withir To the Comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date s	igned (Month,	Day, Year)
	, _	_		George He			59 Y 79		112	1 1200	29
).	1		30. Name and address of person who co	.,MD. 3730	Fall	Road,	Baltin	nore 14	n z	115)	
	Sta Registra		31. Date-filed (Month, Day, Year)	32. Registrar's Signat	ure						
OHM	IH 17 Rev 1/20		JUL 29 2009	Benow S.	far	led					
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 0 0 1.1.1.1.

			1 - For State Registrar	- 10.10 Ca. y.	Ce	rtificate of		Re	g. No.	7 24441
	Physici	an	1. Decedent's Name (First, Middle, Las	,				2. Date of Death Month	Day Year	3. Time of Death
*	/Medic			Edna	Woodla			July 25	, 2009	0500 ™
	Examin	er	4a. Facility Name (If not institution, give	· ·			Location of Deat	h	4c. County of Dea	
magin "	Funeral		Holy Cross Hos 5. Social Security Number 6. Se		yrs. last birthday		r Spring If Under 24 Hrs	8. Date of Birth	Montgar 9. Bir	thplace (State or Foreign
	Director		217-36-8603	TM 2DE	71 Yrs.	Months Days	Hours Min.	Jan 10,	1938 Mai	ryLand
	put 🔏		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
	f sho	ō.			. Oily, lowil of Li		- la aus			1X Yes 2 No
	the N	Director	Maryland Prince (George's		Lial 10f. Zip Code	nham	10	g. Citizen of What Co	
	h with		7319 Oliver St	reet			706		USA	, -
	ems ?	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No-	14. Race - Am	
36	irs afte	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates:		1 □Yes 2X No	Specify:	,		lack
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be redified at once.	Completed	15. Decedent's Ed (Specify only highest grad	ucation	(Give	dent's Usual Occup	durina most of wor	rking 1	6b. Kind of Business	
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≥, ≤	and and marked the mar		Stephanie Woodlan				· · · · ·		MD 20735	
201	Pages 1 ment of H ant: If ite ury or ot		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other plac	i		Oc. Location - City or	Town, State
≝	uit. Pa artmer artant njury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License		Resurred	ction Ceme	e. 8/	3/2009	Clinton, M	MD.
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			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the cone cause on each line.						Approximate Interval Between
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-	/Medical Examiner		resulting in death)	Due to (or as a con	nsequence of):					
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, t	edical	(Check only one)	ysician: To the best of my iner: On the basis of exar and manner stated.	mination and/or ir	nvestigation, in my o	pinion, death occu	urred at the time, da	te and place, and du	e to the cause(s)
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			Canolle	LWill	NID		61937		07/2	6/09
	10 1		30. Name and address of person who c			Print)	REST G	LEN RD	SILVE	R SPRING NO
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Registra	ar	JUL 3 0 20	ON AL	6 1					

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician Month Dale Allen Wright 11:13 A.M Ju1v 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1**₺** м 2□ F Months 55 216 60 5541 Director 10/19/1953 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Baltimore 1 ☐ Yes 2 📉 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 Old Riverside Road 21225 U.S.A. Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗓 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 K No Specify. þ If Yes. Give Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter 11th Meat Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delbert Wright Clydie Whirls ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelley Wright / Wife 525 Old Riverside Road Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 07/31/2009 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, u. co. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** RECTAL CANCER /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy perform 1 ☐ Yes 2**X** No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) **HOSPICE** Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 2 Medical Examiner: On the basis of examiner
Nurse Practitioner stated. 29d. Date signed (Month, Day, Year) 2009

State

DHMH 17 Rev 1/2001

Registrar

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Health and Mental Hygiene, em 27 is marked other than "

permit. Pages 1 Department of H Important: If ite any injury or ot

Examiner

that the death certificate be executed

P.O.

Records,

of Vital

Physician; The law requires

or Attending

death.

To the Hospital within 24 hours a To the Funeral E the Hospital

s after death

attending

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page 2 should

funeral director,

filled in by the

30. Name and ddress of

JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

After this

Pages 1

Baltimore, Maryland 21215-0036

2009

TIMONIUM, MD 21093

person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 11 19 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Bernhard 7,21PM Linka 2009 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Augsburg Lutheran Home Lochearn
If Under 1 Year | If Under 24 Hrs. <u>Baltimore</u> 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day) **Funeral** Year) Months Days Hours Min. 13x M 2□ F Director 390-09-3982 92 22,1916 Wisconsin Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 Tx No Director Maryland Baltimore Lochearn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 s. o.ld be filed within 72 hours after. Department of Health and clental Hygiene. Important: If item 27 is exted other than "natural", or item any injury or other traumetine event. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No White <u>ک</u> Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Senior Packing Technologist Kraft Foods 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Herman H. Zinkgraf Nelda Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 451 Orchard Street; Baltimore, MD 21201

de of Disposition (Name of Date 20c. Location - City or Town, State Bernhard Zinkgraf, Jr Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Atlantic Crematory 7/30/2009 4 Donation 5 Dother (Specify) Glen Burnie, Maryland 22. Name and Address of Facility terling ston cowa fitze Funeral Home of Catonsville, Inc. LIC # MO15-37 1630 Edmondson Avenue; Catonsville, MD 75.11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bolural Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner re bovascular Diseas-e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) archiovascular disease death certificate be executed Arthersclerute and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Box 68760, Physician/Medical as attending IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year signed by the a 5 ☐ Other (specify) Ö 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s been s Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has be 2 s autopsy page ; this certificate of Vital 1∐Yes 2⊅Wo Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA e Funeral Director: After the letely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Drowth Sois Mr 25 Main Street Suite zoo Reisterstown, Md 21136 31. Date filed (Month, Day, Year) 37. Registrar's Signature State 3 0 2000

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician P^{M} 2009 Charles John Abell July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood at Williamsport Washington County

9. Birthplace (State of Foreign Country) Williamsport If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 12,1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X**□M 2□F Jan. Michigan 071-12-7277 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the world at traumatic event, the world at 1 ☐ Yes 2 No Director Maryland Washington County Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 16505 Virginia Ave. 21795 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White 2 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teaher Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Abell Annetta Theuma Abell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9824 Sharpsburg Pike Hagerstown, MD 21740
ace of Disposition (Name of Date 20c. Location - City or Town, State Valerie Bonano-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or o once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 7-21-2009 | Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 or complications that caused the death. 23a. Part 1. Enter the disease, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. a Hospital or Attending Physician: The law requires that the de 24 hours after death.

Funeral Director. After this certificate has been signed by the in leiely filled in by the funeral director, page 2 should be eleached. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed CUTALCULA 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal completely (Check only one) To the within 2. 29b. Signatur 29c. License number

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician July 14, 2009 11:30 p Frederick Lutze Brownholtz /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner 809 Orchard Way Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March 4, 1945 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 215-50-1136 1 **x** M 2 □ F 64 Yrs. Washington, DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amounts and injury or other traumatic event, It. Medical Evantiner must be notified as once. 1 Tyes 2X No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 USA Funeral 809 Orchard Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 □ No Specify. Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William W. Brownholtz Anna Isabelle McMenomy ပ 19a. Informant's Name/Relationship (Type. Print)
Christine Kuehnle/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12765 Spanish Pond Road, St. Louis, MO 63138 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery July 20, 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2009 Silver Spring, Maryland Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signatur of Funeral Service Lice vee Approximate Interval Between Onset and Death 12 years 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Prostate Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: ise yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Year Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No certificate 2 No 1 ☐ Yes 1 □ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**2** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Injury To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D36591 July 15, 2009

Registrar

State

Year)

Dooley, MD

John A.

31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Rouna

3301 New Mexico Avenue, NW, #347, Washington, DC 20016

garke

09-05504 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Nelson Bascome State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ I. Decedent's Name (First, Middle,Last) July 14, 2009 Nelson Blake Ainsworth Bascome 0447 hrs **Medical Examiner** Nelson Bescome 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Montgomery Shady Grove Adventist Hospital Rockville, Md 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Months Days Hours Director 14, SEP. Country) Bermuda 1955 1X M 2 53 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 X No or items 23a or 28a-f show must be notified at once. Pembroke Bermuda None 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ā HM 15 Bermuda 22 Friswell Hill Road Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married Yes 2 X No f Yes, Give Year Yes 2 X No specify: Widowed Divorced Specify: Black ş 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired)
Government Legislator, Elementary/Secondary (0-12) College (1-4 or 5+) Government of 5+ Minister of Health Bermuda 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Gloria M.R. Dickinson Nelson Fitzroy Bascome 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Family Friend 1009 Cypress Road, Wilmington, DE 19810-1905 Austin Culer-Smith. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition Date rematory or other place)
Pembroke Parish 1 X Burial 2 Cremation 3 X Removal from State Ju1y 23, Pembroke, Bermuda 2009 Donation 5 Other Specify Cemetery 21. Signature of Funeral Services ice Licensee Name and Address of Facilit Thibadeau Mortuary 933 Gist Ave., LL, Service, P.A. Silver Spring, M956 MD 20910 23a. Pay. Ent The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and faflure. List only one cause on each line /Medical Death a Acute Coronary Artery Thrombosis Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) b. Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify) by the att 1 Yes 2 No 9 Unknown q Unknown signed by the 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ✔ Yes 2 No 3 Probably 4 Unknown Completed , page 2 should has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 No certificate ✓ Yes 2 No 1 🗸 Yes director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ Nursing Home 5 this Inpatient 2 V ER/Outpatient 3 DOA Residence 6 1 🗸 Yes ို After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 Pending Funeral Director: etely filled in by the 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

32. Registrar's Signature A. Sake

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 14, 2009

cree

s of person who completed cause of death (Item 23a)

Assistant Medical Examiner

20b. Signature and title of certifie

Laron Locke MD.

31. Date filed (Monti Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** John Nelson Barrus, Sr. July 18 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Golden Living Nursing Home Washington County Hagerstown 8. Date of Birth (Month, Day, Oct. 24 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1XM 2□F Days Hours 1920 New York 106-16-8755 88 Oct. Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Maryland Washington County Director Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1012 Washington Ave. U.S.A. 21742 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 1 No. If Yes, Give 1 425 Year or Dates: 1945 Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Press Foreman Printing Company marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nelson B. Barrus Blanche Isabel Raymond Barrus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lynda C. Andrews-daughter 51 Grove St. #5 Tonawanda, NY14150 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem Park 7-23-2009 4 □ Donation 5 □ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) personhae Physician 2 moult carcinama /Medical Due to (or as a conse ence of) Examiner Sequentially list conditions, it any, backing to in model cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy 5 □ Other (specify) ___ 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28365 7.20.09

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State Registrar 368

31. Date filed (Month, Day, Year)

JUL 21 2009

Stra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

's Signature

MANZAR. J SHIPFI.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Items 12&13 per FH 6894 8/10/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 12:05A July 19, 2009 Margaret Ruth Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NMS Healthcare Hagerstown Washington If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 💢 F Director 216-14-5501 87 Dec. 20 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 14014 Marsh Pike 21742 Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21X No Baltimore, Maryland 21215-0036 Completed by Specify: 3 Widowed 4 □ Divorced White 'natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker Domestic alth and Mental Hygid 27 Is marked other r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) W. Carrol1 Melissa Snyder George ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 I 13931 Dry Run Rd. Clear Spring Maryland 21722 Kurt A. Brown / Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot: 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Smithsburg Crematory | 7/21/2009 | Smithsburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalus Funeral Service Lice 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Demon 16 /Medical Due to (or as a consequence of); **Examiner** CLOUPIN Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of): Examiner Hypertension law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown as been signal 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy certificate ha irector, page 2 performed? 1□ Yes 2 1 Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one funeral director Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident neral Director: / filled in by the f 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP ONCUIDIA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Marv Priscilla P^{M} Blank July 19 2009 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood Retirement Center Williamsport Washington 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6, Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🕅 F 216-14-5063 Director Feb. 9, 1920 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Frederick 1 ☐ Yes 2 No Completed by Funeral Director Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10909 Pleasant Walk Road U.S.A. 21773 Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23.
Iny or other traumatic event, the Modical Examinar must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Seamstress Garment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Elizabeth Stotler ဥ George Alfred Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pastor David Coblentz/Excutor 208 S. Jefferson St. Middletown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. Rest Haven Cemetery 7/21/2009 Hagerstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel S. Mu 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cereprovascular accident Imonth /Medical Due to (or as a consequence of) Examiner hypertension years Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine aftending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? gastrointestinal 1 | Yes 2 No 3 | Probably 4 | Unknown bleeding Completed aurtic sknosis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy After this certificate funeral director, pag spital or Attending Physician: The hours after death. Inneral Director: After this certificate y filled in by the funeral director, pa 2 No 1 □Yes 25. Was case referred to medical examiner? å 26. Place of Death (Check only one) Other: 4 Universing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) nthea Kuttner wands, up D47451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nursing Home, 16505 Virgin, a Avenue Cynthia Kuthner-Sands, no Homewood Williamsport, Maryland 21795 M-3 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 07 9:45 AM. lillie Brown 2009 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospita Park Montgomery 5. Social Security Number Adventist lakoma If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01/13/1928 81 Months Days Hours Virginia 244-42-0362 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 SYes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4915 Jay St., N.E. 20019 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc.

African— ^{2 | N}45- '47 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Private Industry Heavy Equipment Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Towne Robert Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie Carrie Brown/Wife 4915 Jay St., N.E., # 14, Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ouantico Nat'l. Cem. 07/22/09 Triangle, Va. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility ngton & Sons Co., Inc. 21. Signature of Funeral Service Licensee 4925 Burroughs Ave., N.E., Washington, D.C. 20019 rale 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pedmonary disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Ground Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? ongestime 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown Peryher 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Pulmoner performed? 2 1No 1 ☐ Yes 1 ☐ Yes 2 □No 26. Place of Death (Check only one) examiner' Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Examine

Physician/Medical

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Certification: To

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d other than "natural", or items 23a or 28a-f show event, the modical Even, insert, wat be notified at

death with the Maryland

within 72 hours after

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygii Important: If item 27 is marked other: any injury or other traumatic event.

Baltimore, Maryland 21215-0036

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hours after death.

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

completely within 2

State Registrar

Garcia mie 31. Date filed (Month

29b. Signature and title of certifier

7600 Carroll Avenue 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland (Department of Health and Mental Hygiene

			1 - For Amend Item State Amend Item Registrar	s 5 per inf.	;;g901°,0372 Ce	23/2010ahl ertificate of	Death	R	Reg. No. 2	109 21151
	Physicia	an	1. Decedent's Name (First, Midd	le, Last)				2. Date of Dea Month	Dav	Year 3. Time of Death
~16s	/Medic		Grace R. Brow					July	15, 20	
	Examin	er	4a. Facility Name (If not institution		-		or Location of Death		4c. County o	George's
4	Funeral		Southern Mary 5 Social Security Number		.1 e (In yrs. last birthday	Clinto	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign
П	Funeral Director		5 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	1□M 2 X F	89 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 08/22/1	, Year) .919	Country) VA
	pu. w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	acation				10d. Inside City Limits
	taryla show	or		e George's	Brandywin					1 X Yes 2 □ No
	28a-f	Director	MD Prince	george s	Diandywin	10f. Zip Code			10g. Citizen of W	/hat Country?
	3a or	i D	12720 Martin R	oad		2061	13			USA
	death	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Evanthar must be notified at once.	þ	1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 ☐ Yes 2 No		Hican, etc.)		k, White, etc. Black
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aŭ	d be ental ked o	To Be	James Price				Nina Abb	•		,
ary	shoul and M s mar umat	۲	19a. Informant's Name/Relations	ship (Type. Print)			and Number or Rui			State, Zip Code)
Ž	and 2 saith a 127 k er tra		Nathaniel Pric	e/Brother	1272	0 Martin	Road, Bra	ndywine	, MD 20	0613
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □ Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)	Date	20c. Location - 0	City or Town, State
<u>Ĕ</u>	Pag tment tant: I		4 □ Donation 5 □ Other (\$		Chesapea			8/2009		ille, MD
Baltimore, Maryland	permit Depar Impor any in		21. Signature of Funeral Services	Licensee . Licensee	/		ess of Facility Str ntown Rd.,			
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that caused tonly one cause on each lir	the death. Do not en	nter the mode of dyi	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between
	Physician	Ì	Immediate Cause (Final disease or condition	-a Respi		ilure				Onset and Death
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Вох	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnand	су		23d. Date Mon	e of delivery oth Day Year
o O	at the de by the a tached f	ysic	1 □ Yes 2★■No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	t time of death 5	Other (specify) _				,
σ.	that the post of t	/ Ph	Part II. Other significant conditi	ions contributing to death bu	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use contri	ibute to the cause of death?
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Division of	teat feat for: the	icat	3 ☐ Suicide 6 ☐ Could		ury - At home, farm, s]Yes 2□No	28f Location (S	Street and Numbe	er or Rural Route Number,
<u>≤</u> .	i Sife	Certification: To	4 ☐ Homicide determ	building, etc	c. (Specify)	reet, lactory, office		City or Tow	n, State)	s of Harar House Number,
	To the Hospital or Ai within 24 hours after or To the Funeral Direct completely filled in by		(Check only 2 Medica	ng Physician: To the best of I Examiner: On the basis of	f examination and/or i	ath occurred at the ti	ime, date and place opinion, death occu	, and due to the or	cause(s) and ma date and place, a	inner as stated. and due to the cause(s)
	To the lawithin 2. To the lawing complet	Medical	one) 29b. Signature and title of certifie	and manner sta	ited.	29c. Licens	se number		20d Date signed	i (Month, Day, Year)
	5 ½ ½ S		255. Signature and the or certific	114	M	1	1 -7r	10	7/16/1	
	_		30. Name and address of person	who completed cause of d	eath (Item 23a) (Tuno	Print)	ء احمال	<i>+</i> 1		1
12	-3		FORZOO N	10/01/00	ian 751	33511	matter	Rd C	linta	n.md 20735
	Sta		31. Date filed (Month, Day, Year,		ar's Signature	1				
	Registr		/ /III	4 / 10 . alan 4 1 /						

	1 - State of Maryland State of Maryland		rtment of H tificate of L			ene g. No. 200	9 2445
Physician	Decedent's Name (First, Middle, Last) MARLENE B	ROWN			2. Date of Death	13 ^{ay} 2009°	3. Time of Death 10:10P M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) MAGNOLIA GARDEN CENTER		4b. City, Town, or LANHAM	Location of Death		4c. County of D PRINCE	eath GEORGE 'S
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. las 1 ☐ M 2 ☐ F 63	st birthday). Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth JAN 26	1946 W	Birthplace (State or Foreign SHTNGTON, DC
Maryland -f show fled at	Usual Residence of Decedent 10a. State 10b. County 10c. City, MD PRINCE GEORGE'S	Town or Lo	cation	RO			10d. Inside City Limits 1X1Yes 2 □ No
with the Mar. 3a or 28a-f st It be routhed	10e. Street and Number 19 HERRINGTON DRIVE		10f. Zip Code 2077	4	10	og. Citizen of What USA	
Tand 2 should be filed within 72 hours after death with the Maryland feleatin and Mental Hygiene. The feleatin and Mental Hygiene the files 71 should not be filed ther than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment must be rediffied at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married In Yes 2 No If Yes, Give Year or Dates:		Nas Decedent of H f Yes, specify Cuba I □Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. BLACK
ed within 72 hor ygiene. her than "natur: t, Ire Medical!	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+	16a. Deced (Give life. L	lent's Usual Occupi kind of work done o DO NOT use retired CHER	ation during most of work t)	ing 1	GOVERNME	·
wild be filed Mental Hyg arked other artic event,	17. Father's Name (First, Middle, Last) WILLIAM P. PROCTOR			18. Mother's Name	e (First, Middle, M TV. DIC		
and 2 shou ealth and N n 27 is ma her trauma	19a. Informant's Name/Relationship (Type. Print) THOMAS M. PROCTOR/BROTHER		•			City or Town, Stat BORO , MAR	e, Zip Code) YLAND 20774
Page:	20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	ce of Dispon netery, cren JERDAI	sition (Name of natory or other plac LE CREMAT	^{e)} ORY 07-16		20c. Location - City RIVERDALE	or Town, State , MARYLAND
permit. Departing any injugant	21. Signature of Funeral Service Licensee		Name and Address			CINS FUNE ER,MARYLA	
Physician /Medical Examiner	23a. Part 1. Enter the disease, o emplications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC Due to (or as a conseque	CERVI			or respiratory arre	est,	Approximate Interval Between Onset and Death UNKNOWN
cate be executed physician and the burial-transit dical Examiner	Sequentially list conditions, if any learning that cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to or as a conseque c. Due to (or as a conseque d.						
The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as tompleted by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown 23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea	leath 3	Ectopic pregnancy	у		23d. Date of Month	delivery Day Year
w requires that been signed I should be deti	Part II. Other significant conditions contributing to death but not resulting HYPERTENSION	ing in the ur	nderlying cause give	en in Part I.	23e. Did tob		e to the cause of death?] Probably 4 Unknown
ysician: The law requires certificate has been significate to page 2 should be Completed.					24a. Was ar autops perforn 1 ☐ Yes 2	y prior ned? deat 2X No 1 □	e autopsy findings available to completion of cause of h? Yes 2 □ No
ysician: T is certificat director, pe	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ El	P/Outpation	ot 3 🗆 DOA Othe	er: X Nursing He		e) ence 6 □Other (5	3-00(64)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, I Medical Certification: To Be C	27. Manner of Death 1 XNatural 5 Pending (Month, Day, Year) 2 Accident Investigation	28b. Time of Injury	28c. Injur Work M 1 🗆		28d. Describe ho	w injury occurred	
bital or Att urs after d sral Direct illed in by	4 ☐ Homicide determined building, etc. (Specify)				City or Town	n, State)	r Rural Route Number,
o the Hospital ithin 24 hours a pube Funeral to ompletely filled	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowl (Check only one) 2 ☐ Medical Examiner: On the basis of examination and manner stated.			ppinion, death occur	rred at the time, d		due to the cause(s)
To vit	29b. Signature and title of certifier			3978	2	7/15/09	onin, bay, reary
R 10	30. Name and address of person who completed cause of death (Item 2 HINA SYED M.D. 7525 GREENWAY CE	NTER	Print) DRIVE SUI	TE 105 G	REENBELT	,MARYLANI	20770
State Registrar	31. Date filed (Month, Day, Year) JUL 1 6 2009 JUL 1 6 2009	re plant					

_			- For Amend Items State of Maryland Department Registrar Amend Items 25,27,28a F per me	artment of the rtificate of	730/09andb M Death	ental Hy	giene Reg. No. 2	009	24453
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of De	Day	Year	3. Time of Death
	/Medic		Robert Michael Bennett			July 4	2009		10:26 p.M.
	Examin	er	4a. Facility Name (If not institution, give street and number)		or Location of Death			nty of Death	
20			St. Mary's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Leonard		8. Date of Bir		Mary's	lace (State or Foreign
	Funeral Director		260–35–0274 1 M 2 F 44 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 12/20/	ay, Year)	Mary]	try)
		,	Usual Residence of Decedent			12/20/_	1704	mary.	tanu
	hours after death with the Maryland tural", or items 23a or 28a-f show at Exantinet to notified at		10a. State 10b. County 10c. City, Town or Lo	cation				11	0d. Inside City Limits
	a-f s	Director	Maryland St. Mary's Abell						1 ☐ Yes 2 💢 No
	ith the	Dire	10e. Street and Number	10f. Zip Code			10g. Citizen o	of What Coun	try?
	ath w		38625 Van Ward Road	20606			United		
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe ban, Mexican, Puerto I	cify Yes or No Rican, etc.)	D- 14. F	Race - Americ Black, White, 6	
36	s afte	by F	1 ☒ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 □Yes 2 🛣 No	Specify:		Spe		
5-0036	hour tural			dent's Usual Occu	ination		16b. Kind of	Whi Business/Ind	
15	filed within 72 Hygiene. xther than "na ent, the Medic	Completed	(Specify only highest grade completed) (Give	kind of work done DO NOT use retire	e during most of workir ed)	ng	11		,
2121	y with giene r tha	E	Elementary/Secondary (0-12) College (1-4or 5+) 12 Brick	Mason			Constr	uction	1
P	afflect af Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle	, Maiden Surn	ame)	
/lar	uld be Menta rrked	2	Hubert Bennett		Lydia Lee	Faunc	e		
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men	. [19a. Informant's Name/Relationship (Type. Print) 19b. Mailir	ng Address (Stree	t and Number or Rura	l Route Numb	oer, City or Tov	vn, State, Zip	Code)
≥	rtr				Great Mil	ls, MD	2063	4	
ore			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Dispo	sition (Name of natory or other pla	ace) D	ate	20c. Locatio	on - City or To	wn, State
altimore,	permit. Pages Department of Important: If ite any injury or o			d-Echols	Cre 07/06	/2009_	Charlo	tte Ha	11, MD
Balt	epart epart nport ny inj		21. Signature of Funeral Service Licensee	2. Name and Addre					ne, P.A.
₩ <u>"</u>	90 E 8 9				lywood Road	d, Leon	nardtow		20650
SWO			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dy	ing, such as cardiac o	r respiratory a	arrest,		Approximate Interval Between
6	Physician		Immediate Cause (Final disease or condition						Onset and Death Minutes
×	/Medical Examiner		resulting in death) Due to (or at a consequence of):				- 6101	1/	
1 D	Lammer	_	Sequentially list conditions, b. Aliway 04	structi	on	0 HU	MEDICAL EXAM	NER	minutes
	ted sit	nine	Sequentially list conditions, if a ry, leading to himmediate cause. Enter Underlying Cause (Disease or injury		(Du	961.	MEDICAL EXAM	INE	
7.	cate be executed oblysician and the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		CERTIFICATION	APPROVED BY	Ma		
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€ 88 88	fficate p phy: s the	edic	d						
× ŏ	death certific e attending p ed for use as t	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy				23d.	Date of delive	ery
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0.0	at the de by the tached	hys	9 ☐ Unknown			_			
t, s	w requires that s been signed I should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause gi	iven in Part I.	23e. Did	tobacco use co	ontribute to th	ne cause of death?
2 p	en sig					1 🗆	Yes 2 □ No	3 Prob	ably 4 Unknown
Sperior	law re as be 2 sho	plet				24a. Was	an 24	b. Were auto	psy findings available mpletion of cause of
>\mathrew{\pi}	The late has	Completed				auto perfo 1 □ Yes	ormed? 2 MNo	death?	2 No
Vital	Attending Physician: The law requires that the rideath. cctor: After this certificate has been signed by the funeral director, page 2 should be detache by the funeral director, page 2 should be detached.	Be C	25. Was case referred to medical examiner?		26. Place of Death			1 100	
-	hysic his ce I direc		1 X Yes 2 Hospital: 1 ☐ Inpatient 2 X ER/Outpatier	nt 3 DOA Oth	her: 4 ☐ Nursing Hor	ne 5 🗆 Res	idence 6 🗆 (Other (Specif	y)
17 noi	ding Phy n. After this funeral c	Certification: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	n Wo	ury at 2	8d. Describe	how injury occ	curred	olus of
Benne	tendi eath. or: A the fu	cati	2XAccident investigation 07/04/2009 Unknow	n M 1□	Yes 244NO	.ood			
Z S	or At after d Direct in by	ŧ	determined determined building, etc. (Specify)	eet, factory, office					Route Number, nion Fields
	urs a urs a eral E		yard				reat M		
	Hospital 24 hours a Funeral I stely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the t vestigation, in my	time, date and place, a opinion, death occurre	and due to the ed at the time	e cause(s) and , date and plac	I manner as s ce, and due to	tated. the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Mec	29b. Signature and title of certifier /	29c. Licen	se number		29d. Date sig	ned (Month.	Dav. Year)
	F 3 F 8		M. A. C. T.						•
		-	20. Name and address of passes who completed course of death (the CC) /T		068427		Jul	4,3,	2009
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Box	5211	00.	14	. M.	220158
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	,001	- 07 L	way	OTOU	1,/1/	20636
	Registra		JUL 2 0 2009 Calus A. Soc	Med .					
DH	MH 17 Rev 1/20	001	p. M.						
			ORIG	INAL.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year July 15, **Physician** Marina Antonia Borbon 8:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 15, 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2**X**□ F 56 1953 Dominican Rep. 072-84-6226 Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits show er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1¥ Yes 2 □ No Director DC Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3130 Wisconsin Avenue #B-2 20016 Dominican Republic Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iten 1 ☐ Never Married 2 ☐ Married <u>ک</u> If Yes, Give Year or Dates: 1 X Yes 2 ☐ No Specify: Dominican Specify: Hispanic 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Chef **Embassy** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miquel Angel Duran Rodrigues (unk) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cristian Borbon/son 11220 Evans Trail #102 Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crematory 07/16/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Gaing Mones Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) tongemic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of) attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe certificate 2 \square No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

be exect Box 68760. o ۵. Division of Vital Records,

death

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I.

29a. Certifier

(Check only one)

29b. Signature ar

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m

and manner stated.

400 egistrar's Signature

th Street Frederick, MD

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Ü

St. Beavers

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 12 2009 Month Day Physician 858 PM Beaven ret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Point Kent ron Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 X M 2 □ F Months Days Hours 220-36-6852 **Director** 90 1918 Maryland Aug. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at 1XYes 2 No Director Maryland Kent Chestertown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21620 U.S.A. 501 East Campus Avenue, Apt. 248 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ed Forces? Yes 2 \sum No Armed Forces?
1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 1942-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Completed by 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sterrett P. Beavan,DDS Elementary/Secondary (0-12) College (1-4or 5+) Dentist/Self-Employed Catonsville, Maryland Six Years nd 2 should be filed with and Mental Hygier 27 is marked other the traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important if flem 27 is more any injury or other conce. Be Arthur Beaven Elsie Annie Patterson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren S. Beaven 75 Tanyard Lane, Huntington, New York 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State Hopewell Cemetery 07/20,09 Port Deposit, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766 re of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause, in each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any conditions, if any conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 ☐No 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2, ☐ No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending 1 ☐ Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mann 29d. Date signed (Month, Day, Year) 29b. Signatur D0060301 and address of person who completed cause of death (Item 23a) (Type, Print)

HT WEN NO 122 STORM RU STETS CHOSTONION, WI 21650 OFIVA 32. Registrar's Signature JUL 17 2009 Registrar

9-05/40		Please Type or Print in Black Indelible Ink. Ensu			ible.	
nathin Rian B	rowi	that of many and a partition of house, a	and Mental H	ygiene	200	9 2445
		Registrar Certificate of Death		Reg	J. NO.	
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last)			Day Year	3. Time of Death 1130 hrs
Calcal Exami	1101	Jonathin Rian Brown 4a. Facility Name (if not institution, give street and number) 4b. City, Town,	or Location of Death		4c. County of Death	11001113
		110 Milestone Road Elkton			Cecil	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24Hrs	. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	nplace (State or
Director			ays Hours Min.	FEB 7	Foreig	Maryland
		Usual Residence of Decedent		FED /	1900	
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
* .	'n	Maryland Cecil Elkton				1 X Yes 2 No
daryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code	е	10	g. Citizen of What Cour	try?
th the M 23a or 2 notified		110 Milestone Road 2193	21		United Sta	ites
with ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp ban, Mexican, Puerto			can Indian, Black,
deatl or ite	-un	1 Yes 2 X No		Riodii, etc.)	winte, etc.	
s after	by	3 Widowed 4 Divorced of Divorced or Dates:			Specify: Whi	
hour natu	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup during most of working life (1-4 or 5+)			16b. Kind of Business/li	ndustry
36 thin 72 than 'than' edical	ble	12 Self-employed	d Landscar	or	Landscap	ina
5-0036 led within 72 Hygiene. I other than "	Comple	17. Father's Name (First, Middle, Last)	18.Mother's Name			TIIg
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be (Michael Brown	Julia N	M. Walke	r	
213 ould b d Men s mar	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str				Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiewill homeranes. If item 27 is marked of ther than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Michael Brown/Father 110 Mileston		Elkton,		
re Te Titen fiten		20a. Method of Disposition 20b. Place of Disposition (Name of or crematory or other place) Removal from State	cemetery,	Date y 24,	20c. Location - City or	Town, State
Pages ent of		4 Donation 5 Other Specify: R. A. Ferris & Co.,			West Che	ster, PA
Baltimore, permit. Pages I an Department of Hea Important: If iter		21. Signature of Funeral Service Licensee 22. Name and Addre	ess of Facility		2 4	,
0 88 5 5 5		Donard S. Dicks 103 W. St	ess of Facility ne for Fun tockton St	reet. E	lkton. MD	21921
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyin failure. List only one cause on each line.	ng, such as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease a. Asphyxia			1	Death
		or condition resulting in death) Due to (or as a consequence of): b. Hanging				
	ē	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
cuted and transit	Ě	events resulting in death) Last Due to (or as a consequence of):				
exe	sician/Medical	UNPENDED AMENDED				
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cath certific attending properties	ian/	past 12 months?	3 Ectopic pregna	ancy	Month D	ay Year
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O. B. nat the de de by the de stached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	23e. Did tol	pacco use contribute to	the cause of death?
ires that signed be deta	d by			1 Yes	2 V No 3 Prob	ably 4 Unknown
rds requi	Completed			24a. Was a autops		topsy findings available ompletion of cause of
eco ne law te has ge 2 sl	Ĕ			perform	ned? death?	
tal Recian: The		25. Was case referred to medical 26.Pla	ace of Death (Check			3 2 110
Vita hysicia this ce	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other Nursin	ng Home 5 F	Residence 6 🗸 Other	: Scene
Division of Vital Records, state or Attending Physician: The law requirated redected that General Annual Directors. After this certificate has been stell in by the funeral director, page 2 should I	-	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. In	njury at Work?	28d. Describe h Subject hand	ow injury occurred	
ion tendi tor: ,	gi	1 Natural 5 Pending FOUND: 1 2 Accident Investigation Jul 22, 2009 1057 hrs	Yes 2 V No	Subject nang	jeu sen	
Divis pital or At ours after d eral Direc filled in by	iji.	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	e building, etc.	28f. Location (Son Town, St	treet and Number or Ru	ral Route Number, City
Division spital or Attend hours after death. neral Director:	Certification:	4 Homicide determined (Specify) Single Family Residence		110 Milestone	Road, Elkton, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, one) Wedical Examiner: On the basis of examination and/or investigation, in my opini				
To To com	Med	and manner stated.	ense number		29d. Date signed (Mor	
			C.M.E.		July 23, 2009	,
		30. Name and address of person who completed cause of death (Item 23a)				
-			et, Baltimore, M	D 21201		
	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature				
Regist	car	JUL 2 9 2009 Chauch B. 1900				

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ORIGINAL

			1 - For State Registrar	State of Ma	aryland		artmen <i>tificat</i>			nd Me		ene g. No.	009	24457
	Physici	an	1. Decedent's Name (First, Middle, Last Brenda Faye Ct								Date of Death Month	Day 15	Year	3. Time of Death
	/Medic Examin	cal	4a. Facility Name (If not institution, give 10301 Strathmon	street and number)	St.			Town, or	Location of	Death	/	4c. C	2009 County of Death Iontgo	1
	Funeral Director			x 7. Ag ☐ M 2	e (In yrs. la 56	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day, 7 – 18 – 1		Cot	pplace (State or Foreign intry) ton Miss.
	Maryland 8-f show iffed at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Montgom	ery		, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28	ai Dire	10e. Street and Number 10301 Strathmo:	re Hall	st.		10f. Zip		852		10	g. Citize	on of What Cou	•
920	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "neturel", or items 23a or 28e-f show event, it a Medical Eranifier must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Deced f Yes, spec l □ Yes			in? (Spec Puerto F	efy Yes or No- lican, etc.)		4. Race - Amer Black, White Specify: B1	, etc.
Maryland 21215-0036	e filed within 72 ho il Hygiene. other than "netui vent, the Medical	ompieted	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5	ō+)	16a. Deced (Give life. L	lent's Usua kind of wo DO NOT us Atto	rk done d se retired	luring most)	of workin	g		of Business/I	-
/land		To Be C	17. Father's Name (First, Middle, Last) Moody Bully Ro	binson							(First, Middle, N Moncri	_	iumame)	
, Mar	d 2 sh th and 7 ls m treum		19a. Informant's Name/Relationship (7) Laverne Buckle											53218
Baltimore,	m O		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,			ace of Dispo- emetery, cren easant	Gr	ove		-24	-2009 ₁	New.	ation-City or 1 ton Mi	.ss.
Bal	permit. Page Department of Importent: If any injury or		21. Signature of Funeral Service Licens Tranco 23a. Part1. Enter the disease, or comp	Hunt		91	08 K	enne	edy S	st N	nt Fune .W. Wa	sh,	D.C.	20011
	Physician /Medical Examiner	ner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	ne cause on each lir	ne. reati a consequ	ic Cai								Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):								
.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pr Other (sp					23	3d. Date of deliment	very Day Year
rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death b	ut not resu	alting in the ur	nderlying c	ause give	n in Part I.			accous s 2∑(∑		the cause of death? bably 4 \(\subseteq Unknown \)
al Records,	The ate h page	Completed									24a. Was ar autops perform 1 Yes 2	/	24b. Were aut prior to c death? 1 🗌 Yes	opsy findings available ompletion of cause of
Vital	Physician: this certific al director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	wt 2 🗀 s	ER/Outpatien	t 3 🗆 DC	Othe	NP-		(Check only one e 5 🗴 Reside		Cothor (Space	(64)
of	ing After uner	l Hu	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day		28b. Time of Injury		8c. Injury Work	4 10 10 10 10 10 10 10 10 10 10 10 10 10	2	Bd. Describe ho			,
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	To the Hospitel of within 24 hours af To the Funeral D completely filled in	Medical ((Check only 2 Medical Examone)	sician: To the best iner: On the basis of and manner sta	fexaminat		estigation	, in my op	oinion, death		d at the time, da	te and p	olace, and due	to the cause(s)
	To t With To t	Σ	29b. Signature and title of certifier	estifo n	D			DC (5165		29		16-20 (
_	15		30. Name and address of person who can also also also also also also also also	o Ave. N	. W.	Wash,	Print) D.(2. 2	0016					
	Sta Registr		31. Date filed (Month, Day Year) JUL 1 7 2009	32. Registr	's Signa	artis								

		1 - State Registrar			and / Depa	artment of his	Health a		lental Hy		21110	24450
		Decedent's Name (First, Middle,	Last)						2. Date of De	ath		3. Time of Death
Physici		RUTH	Ε.		CRC	SBY		-	Month JULY	Day	Year 2009	10:00P M
/Medi Examir		4a. Facility Name (If not institution,		number)	Onc	4b. City, Town, o	or Location o		уошт		County of Death	
LAdiiii	ici	1209 NYE STREET				CAPITOL	HETGE	HTS		PR.	INCE GEO	ORGE
Funeral			6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da		9. Birth	pplace (State or Foreign intry)
Director		577-62-4459	1 □ M 2 🔀 F	7	7 Yrs.	Months Days	Hours	Min.	12-27-			HINGTON. DC
P		Usual Residence of Decedent										
ırylar Show	_	MD 10b. County PRINCE	CEODCE	1	. City, Town or Lo							10d. Inside City Limits
e Ma	cto	MD PRINCE	GEURGE	CA	PITOL HE	IGHIS						1 XYes 2 No
id X 1X 13-0030 filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Mudical Examinat: ust be motified at	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Cou	intry?
ath w	<u>ra</u>	1209 NYE STREET	T			20743					S.A.	
er de	Funeral	11. Marital Status	Armed	cedent Ever i Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Ori an, Mexican	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 1	 Race - Amer Black, White 	
s affe	by F	1 ☐ Never Married 2 ☐ Marrie 31☑ Widowed 4 ☐ Divorced	If Yes, (1 □Yes 2√∑No	Specify:				Specify: BLA	ACK
hours a tural", c	a b	-At	Year or	Dates:	16a Dage	dent's Usual Occup	nation				d of Business/li	
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withii ene.	E E	Elementary/Secondary (0-12)	College	(1-4or 5+)		OD SERVI	•			CO7	ZERNMENT	n
Hiled Hygied ent.		17. Father's Name (First, Middle, L	ast)		1 10	OD BERVI		er's Name	(First, Middle			
d be ental ked c	To Be	WILLIAM SMITH					GERTE	RUDE	COATS			
Tallylaillo ZIA	1	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Maili	ng Address (Street	1			er, City or	Town, State, Z	ip Code)
and 2 sealth a n 27 is		THOMAS CROSBY/SO	ON		9502	STONEY HA	ARBOR	DR F	T. WAS	HINGT	ON, MD	20744
D - I 9 =		20a. Method of Disposition		20	b. Place of Dispo	osition (Name of matory or other pla		D	ate	20c. Lo	cation - City or T	own, State
the Pages the transfer of tant: If its ijury or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		n state	ARMONY C			7-21-	-2009	TANT	OVER,MI	`
ortar Populariti		21. Signature of Funeral Service L				2. Name and Addre						
permit. Departr Importa any Inje		K. N.	U _l. a	$\cdot \cdot \cdot \cdot \cdot$		474 LANDO						
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h cer endir use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		outcome of pro		☐ Ectopic pregnand	0			2	3d. Date of deli	very
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vical necolor sician: The law requir certificate has been s rector, page 2 should		25. Was case referred to medical					26 Place	e of Death	1 ☐ Yes		TLITES	2 □No
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ding Physician: The In. After this certificate h funeral director, page	Ë	27. Manner of Death	28a. Da	te of Injury	28b. Time o		iry at		28d. Describe			
nding Path.	aţie	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga		onui, Day, rea	17) 11quiy]Yes 2□	No				
Afte Afte ecto	Certification: T	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	20e. Fla	ce of Injury - /	At home, farm, str	reet, factory, office		:			1 Number or Ru	ral Route Number,
s affe	ert	4 El ronnolde	bui	iding, etc. (Or	, cony				City or To	wii, Siaie)		
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To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	edical	(Check only 2 Medical E		anner stated.	mnation and/of If	ivestigation, in my	ориноп, аев	zin occurr	eu at the time,	uate and	piace, and due	to the cause(s)
To t Vith	Ž	29b, Signature and title of certifier	0			29c. Licens					e signed (Month	•
		D/ water	201.5C)		140	666	55		07	115/2	2009
-		30. Name and ress of person w	ho completed ca	use of death	(Item 23a) (Type,	Print)	01.	1	4.00	,	15/2	,
5		Dr. Dona Leski	USKI DC	92	009ri	4 Tle	100	1	4KG0	M	0207	74
Sta		31. Date filed (Month, Day, Year) 1 6 2009	32.	Registrar's S	ignature					,		,
Regist	rar	JUL I O ZOUS	follower.	1 P.	gaves							

		State of Maryland / Depart For State Registrar Certification State of Maryland / Depart	ment of Health and ficate of Death		giene 2009	24459
Physicia		Decedent's Name (First, Middle, Last) ROSE CARTER		2. Date of Dea Month JULY	Day Year 2009	3. Time of Death 10:20 P M
/Medic Examin		4a. Facility Name (If not institution, give street and number) 4	b. City, Town, or Location of De		4c. County of Death MONTGOMER	
Funeral Director	·		f Under 1 Year If Under 24 H Nonths Days Hours Mi		h 9. Birthi	place (State or Foreign ntry) INGTON, DC
ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat	ion		1	0d. Inside City Limits
the Ma 28a-f s	Director	MD PRINCE GEORGE'S LANDOVER	10f. Zip Code		10g. Citizen of What Cour	1 AYes 2 No
h with	al Dir	8109 LANDOVER ROAD	20785		USA	
If F, INTALY ITAING ZIZIS-UUSO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Medical Examinational bandlified at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	s Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pud Yes 2 XNo Specify:	(Specify Yes or No- erto Rican, etc.)		
within 72 ho eiene. than "natur re Medical!	Completed	(Specify only highest grade completed) (Give kin life. DO	t's Usual Occupation d of work done during most of и NOT use retired)	vorking	16b. Kind of Business/In	dustry
nd 21 e filed wi al Hygier other th		8th HOU 17. Father's Name (First, Middle, Last)	JSEKEEPER 18. Mother's N	ame (First, Middle,	PRIVATE Maiden Surname)	
Ian Ild be f Mental rked o	To Be	GEORGE PIERCE		RY MICKEN	•	
Marylan d 2 should be th and Menta 7 is marked traumatic ev			Address (Street and Number or			
altimore, IM mit. Pages 1 and 2 partment of Health portant: If item 27 i y injury or other tra <u>ce</u> .		20a. Method of Disposition 1 N Rurial 2 Commation 3 Removal from State 20b. Place of Disposition cemetery, cremation	PERRYWOOD COUR on (Name of ory or other place) LN CEMETERY 7/	Date	4ARLBORO, MAR 20c. Location - City or To BRENTWOOD, M	own, State
Daltimor permit. Pages Department of Important: If it any injury or o	İ	K.D.M-hall	ame and Address of Facility	OAD LANDO	ENKINS FUNER OVER.MARYLAN	
The law requires that the death certificate be executed the law requires that the death certificate be executed the law requires that the death certificate by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	23a. Part 1. Enter the disease or complications that caused the death. Do not enter to shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to minimize that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	7 C HEAVET	DISETA	36-	Approximate Interval Between Onset and Death
the death certific	Physician/Med		ctopic pregnancy ther (specify)		23d. Date of deliv Month	ery Day Year
ecords, P.O. law requires that the de as been signed by the 2 2 should be detached i	by	Part II. Other significant conditions contributing to death but not resulting in the unde cerebralvascular accident	erlying cause given in Part I.		obacco use contribute to t Yes 2 ♣ No 3 ☐ Pro	
on or vital mecord ding Physician: The law requir h. After this certificate has been s funeral director, page 2 should	Completed	25. Was case referred to medical	00 Place of 5	24a. Was autop perfor 1 Yes	prior to co rmed? death? 2 \(\overline{A} \) No 1 \(\overline{A} \) Yes	opsy findings available empletion of cause of 2 □ No
nysicia nysicia nis cert	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Lou		dence 6 □Other (Speci	fy)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, r	Certification:	27. Manner of Death 1	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe h	now injury occurred	
ital or Att irs after d ral Direct		determined determined building, etc. (Specify)		City or Tow		
e Hosp 24 hou e Fune letely fi	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death o 2 ☐ Medical Examiner: On the basis of examination and/or investant manner stated.				
To the within To the comple	Me	29b. Signature and title of certifier August V. Halle Sules ince	29c. License number		29d. Date signed (Month,	
21		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	nt)	i i	JULY 14, 2	009
RY		DORIS BUSTOS M.D. 1140 VARNUM STREE 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ET N.E. WASHING	TON, DC	20017	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Against Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	for State of Maryland / Depart State of Maryland / Depart Registrar Certification Cert	ment of Health and I ficate of Death		iene eg. No. 🤈 🎧 🖺 🔾	24460
Ph	ysicia	_	Decedent's Name (First, Middle, Last) ELLEN, CARCON, CACRADIAN		Date of Death Month	Day Year	3. Time of Death
/Medical			ELLEN CARSON CASBARTAN 4a. Facility Name (If not institution, give street and number) 44	o. City, Town, or Location of Death		4c. County of Death	11:40 A M
			704 ROBIN HOOD HILL	SHERWOOD FOREST		ANNE ARI	INDEL
Fun Dire			577-50-2306 1□ M 2\ F 74 Yrs. M	Under 1 Year If Under 24 Hrs. In Index 2	8. Date of Birth (Month, Day, FERLARY)	9. Birth 2,1935 WASH	place (State or Foreign aftry) ILNGTON, D.C.
land	Ħ	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	on		1	0d. Inside City Limits
e Mary a-f sh	ified	cto	MARYLAND ANNE ARUNDEL	SHERWOOD FOR	REST		1 □Yes 2 X No
vith the	pe no	۵		10f. Zip Code	10	0g. Citizen of What Coul	
leath v	must	Funeral	704 ROBIN HOOD HILL 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21405 Decedent of Hispanic Origin? (Sp	pecify Yes or No-	UNITED S	
21215-0036 d within 72 hours after death with the Maryland gjene. er than "natural", or items 23a or 28a-f show	2	ğ	1 □ Never Married 2 M Married 1 □ Yes 2 M No	Becedent of Hispanic Origin? (Sp.s., specify Cuban, Mexican, Puerto Yes 2 No Specify:	Rican, etc.)	Black, White, Specify: WH	etc.
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arylan should be and Mental s marked o	atic ev	၉	EARL CARSON	FANNIE	WRIGHT		
Maryland of 2 should be file th and Mental H) or is marked oth	traum		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing A HARVEY T. CASBARIAN, JR. / HUSBAND 704 RO	ddress (Street and Number or Rus			
re, N s 1 and of Health item 27	other	9-	20a. Method of Disposition 20b. Place of Disposition	on (Name of	Date 2	20c. Location - City or To	
imor Pages nent of ant: If its	ury or		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	2009 8	TEVENSVILL	E, MARYLAND
Baltimore, permit. Pages 1 ar Department of Hea Important: If item:	any inj		21. Signature of Funeral Service Licensee **CRE ROAL** **ROAL** **CRE ROAL** **ROAL** **ROAL** **Property of Funeral Service Licensee** **Property of	ame and Address of Facility FEI MATION AND FUNER D, ANNAPOLIS, MA	LOWS HE	LFENBEIN AN P.A. 814	D NEWNAM BESTGATE
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Physic	_	1	Immediate Cause (Final disease or condition resulting in death)	n Caney			Onset and Death
/Med Exami	_		Due to (or as a consequence of):	or laney			
	+-	le	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events cause.	and July			
ecute	trans	Examiner	Cause (Disease or injury that initiated events c				
68760, rificate be executed ig physiclan and	burial		Due to (or as a consequence or).				
Box 68760, eath certificate be executed attending physician and	as the	ledical	a				
	or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ed	etopic pregnancy		23d. Date of deliv	ery Dav Year
P.O. Box nat the death ce d by the attendi	shed fo	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	ther (specify)		Month	Day Teal
	detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
cords w requires been sig	ad bluc	ed b			1 □ Ye	s 2 → No 3 → Pro	oably 4 ☐ Unknown
Records, he law requires the has been signer	2 sho	Completed			24a. Was ar autops	y 🖈 prior to ed	ppsy findings available mpletion of cause of
Vital Riclan: The certificate I	r, page				perform 1 □ Yes 2	ned? death? P. ☑No 1 ☐ Yes	2 □No
f Vital nysician: Ti nis certificate	irectol	e Re	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ 100 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient :	Other:	th (Check only one	<u> </u>	
n of g Phy ter this	eral d	<u> </u>	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe ho	nce 6 ☐ Other (Speci w injury occurred	9//
Vision (Attending I death.	the fur	catio	2 Accident investigation	M 1 □Yes 2 □No			
Division of tal or Attending Phy. Is after death.	filled in by 1	Certification: T	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Sti City or Town	reet and Number or Run , State)	al Route Number,
To the Hospital within 24 hours a To the Funeral C			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ccurred at the time, date and place tigation, in my opinion, death occu	, and due to the carred at the time, da	ause(s) and manner as ate and place, and due t	stated. the cause(s)
To t	moo :	Σ	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month,	Day, Year)
		-	Curla (starra, MD	1955506		413/6	211111
-1	246		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	Bests ate Ra	1 ste	300 Anna	nolis mon
	State		31. Date filed (Month, Day, Year) 32. Registrar's Signature			7,7,000	
	gistra	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's A. factor	Ţ			
DHMH 17 R	ev 1/200	J1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2009 Augusta Danner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital 8. Date of Birth (Month, Day, Year)
June 27, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F 1919 Maryland 90 Director 215-14-2645 Usual Residence of Decedent 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b County "natural", or items 23a or 28a-f sho 1 □Yes 2No Director Knoxville Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21758 U.S.A. 2157 Reed Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify Specify: à White 3 Widowed 4 □ Divorced Completed 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Younkins Arthur L. Nokes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Danner / Son 108 N. Main Street Keedysville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Brownsville Heights Cem 7-24-09 Brownsville, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Bast-Stauffer Funeral Home, P.A. 21713 7606 Old National Pike Boonsboro, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) R Physician Acut /Medical Due to (or as a consequence of): Examiner myelopalipe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 physician use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) detached 9 I Inknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 2 No 1 ☐Yes 2 ☐No 1 □ Yes certificate C. Dimicie Hospital or Attending Physician: ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 4 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D18015 -out mo JULY 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21740 MILLST MAGERSTOWN DATTA VASAVT 20 340 5H-L 31. Date filed (Month,) 32. Registrar's Signature State 2009

DHMH 17 Rev 1/2001

Registrar

17. Father's Name (First, Middle, Last) Thomas J. Dee

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Evention or out to nother at

7 is marked other traumatic event, the

Department of Health Important: if Item 27 any injury or other tr. once.

Physician

/Medical

Examiner

attending physician and for use as the burial-tran

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certificate

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within 24 hours after death To the Funeral Director: completely filled in by the

3

After this funeral of

the Hospital or Attending Physician; The law requires that the death certificate be executed

Box 68760,

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Division of Vital Records,

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Examine

Physician/Medical

2

Completed

Be

Certification: To

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Medi

filed within 72 hours after death with the Maryland

should be filed within and Mental Hygiene.

Pages 1 and 2 s ment of Health an ant: if Item 27 is:

Baltimore, Maryland 21215-0036

Margaret O'Brien 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type. Print) 6117 41st Street, Hyattsville, MD 20782 Margaret Dee / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

20c. Location - City or Town, State Date

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemet 7/21/09 22. Name and Address of Facility 21. Signature of Funeral Service License

4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, PA

23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

wonde Due to (or as a consequence of): Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 5 Other (specify)

3 Ectopic pregnancy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No robably 4 Unknown

23d. Date of delivery

Month

Silver Spring, MD

Approximate Interval Between Onset and Death

24a. Was an autopsy 1 □Yes

performed 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 1∐ Yes 27. Manner of Leath Natural

29b. Signature and title of certifier

18

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

Hospital:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

4 Homicide

3 ☐ Suicide

The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address

State Registrar

and manner stated.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryland		tificate of L			eg. No. 2	09	24463
Pi	1. Decedent's Name (First, Middle, Last) Physician Toppi for C Dov.lo						2. Date of Deat	Day	Year 2009	3. Time of Death
	/Medical Jennifer G. Doyle 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			13, 2009 11:20 a ^M		
	Admin		194 Doncaster Road		Arnold			Anne Arundel		
	neral ector		5. Social Security Number 6. Sex 1 □ M 2 💢 F 60 7. Age (In yrs. last	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 20	(Year)	Cou	place (State or Foreign Intry) SISSIPPI
and	A set		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Loc	ation					10d. Inside City Limits
DEBITIMOTE, IMBRYISHO ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	iffied a	ctor	MD Anne Arundel	Arnol	.d					1 □Yes 2 🏋No
	II", or Items 23a or 28a	al Dire	10e. Street and Number 194 Doncaster Road	ing.	10f. Zip Code 210	12	1	0g. Citizen of US A		intry?
		by Funeral Director	11. Marital Status 1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 【 No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba □Yes 2 X No	ispanic Origin? (Spanic Origin? (Spanic Origin), Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ack, White,	ican Indian, etc. hite
Z I Z I 3-UU30 I within 72 hours aff giene.	Medical B	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	6a. Deced (Give k life. D	ent's Usual Occup kind of work done o O NOT use retired	ation Juring most of worki Manager	of the	16b. Kind of E		'
Z I Z be with ygiene	t, the	Com				Support C	enter			College
/land uld be file Mental Hy	c even	Be c	17. Father's Name (First, Middle, Last) Henry H. Grantham, Sr.			18. Mother's Name Bettye			me)	
aryi shoulk and Me	s mari	ဍ				and Number or Run	al Route Numbe	r, City or Towr		ip Code)
e, M 1 and 2 Health	her tra		Frank S. Doyle / Husband			r Road A		MD 2101 20c. Location		'awn State
Daltimore permit. Pages 1 Department of H	ant: If iter ury or oth				sition (Name of latory or other place ematory,		716 , 09	Baltin	-	
permit.	any Inj once.	4	Signature of Funeral Survivo Licensee	Ba 49	Pranco & 5 Gov. R	ss Sons, P. itchie Hw	A. Seve	rna Par rna Par	ck Fu	neral Home D 21146
			Part 1. Enter the disease, or complications that caused the death. s pck, or heart failure. List only one cause on each line.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death
Physi /Me	ician dical	1	Immed, to Cause (Final disease or condition resulting in death) a. Panchat C Due to (or as a consequent		. 4/				-	2 years
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ords, F.O. box or requires that the death certific neen signed by the attending prould be detached for use es t	thed for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ Nó 9 □ Unknown 23c. If yes, outcome of pregnanc: 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 🗆	Ectopic pregnanc	у			ate of deliv	very Day Year
s that t	e detac	by Ph							o use contribute to the cause of death?	
Ord: equire	ate has been s page 2 should	ted b					1 🗆 Y	es 2□No	3∏ Pro	obably 4 □ Un known
The law		Completed					24a. Was a autops perfor 1 \(\text{Yes} \)	sy med?	prior to o death?	opsy findings available completion of cause of 2 답No
VITAI sicien: T		Be	25. Was case referred to medical examiner? Hospital:		Oth	26. Place of Deatler:				
g Phys		<u>ان</u>	27. Manner of Death 28a. Date of Injury 28	NOutpatient Bb. Time of Injury	t 3 DOA 28c. Injur	y at	me 5 Resid 28d. Describe h			cify)
r Attending Phy er death.		catio	2 Accident investigation		M 1 □	Yes 2 □ No				
UIVI:	ed in by	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	iber or Rui	ral Route Number,
DIVISION OF VITA To the Hospital or Attending Physicien: within 24 hours after death. To the Europe Directors After this contified	completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.							
Vithii	comp	Ĭ	29b. Signature and title of certifier		29c. Licens	e number	2	29d. Date sign	ed (Month	n, Day, Year)
		}	30. Name and address of person who completed cause of death (Item 2:	3a) (Type F	Print)	111-15		0 // 1	3/0	1731
CAL	5		Niloff Azal		401 N	weth B	Roade	ay,	BATI	mace, and
R	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signatur	4. 6	ares			l		

09-05366 Jason Derby Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ison Derby			ment of Health and Mental Hy iicate of Death		200	9 2446
Physicia	an/	1. Decedent's Name (First, Middle,Last)		Reg. No 2. Date of Death Month Day	J	3. Time of Death
ledical Exami		Jason Derby		July 8, 2009		0900 hrs
		 Facility Name (if not institution, give street and number) 1203 Fidler Lane #902 	4b. City, Town, or Location of Death Silver Spring		tc. County of Death Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MN 09/21/19	Cou	nplace (State or Foreign Intry) lifornia
ow any	-		wn or Location er Spring	<u> </u>		10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 1203 Fidler Lane, Apt. 902	10f. Zip Code 20910	10g. C	itizen of What Coun	try?
r death with or items 23 must be no	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc. Specify: Whi	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	eted by	Elementary/Secondary (0-12) College (1-4 or 5+)	 Decedent's Usual Occupation (Give kind of w during most of working life, DO NOT use retired 		, Kind of Business/li	ndustry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Comple	12 17. Father's Name (First, Middle, Last) Richard Derby	Soldier 18.Mother's Name Joy Wo	(First, Middle, Maide	U.S. Ar	my
MD 212 nd 2 should b alth and Meni m 27 is marl		19a. Informant's Name/Relationship (Type, Print) Wendy Brown / sister	19b. Mailing Address (Street and Number or F 5591 West Kootenai Ro	Rural Route Number, Rexfo	_	9930
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati		1 XBurial 2 Cremation 3 Removal from State	oaquin variey can	8/2009 _S	anta Nell al Home	
	y. 8	23a. Part I. Enter the disease, or complications that caused the death. Do	6512 NW Crain Hwy.	Bowie,	MD 2071	5 Approximate Interval
Physician /Medical xaminer	8 8	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. That Gunshot Wound of Due to (or as a consequence of):				Between Onset and Death
ii I	Examiner	Sequentially list conditions, if any, leading to immediate constructions. Enter the enterprise Cause (Disease or injury that initiated events resulting in death) Last	=			
60, ate be executed hysician and te burial - transit		d		V.		
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed teath. for: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	23d. Date of delivery Month [/ Day Year		
rds, P.O. E	by	Part II. Other significant conditions contributing to death but not resu	ilting in the underlying cause given in Part I.	1 Yes 2	o use contribute to	pably 4 Unknown
of Vital Records, ng Physician: The law requir the this certificate has been s neral director, page 2 should I	Completed		_		prior to o	atopsy findings available completion of cause of
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 EF	26.Place of Death (Check R/Outpatient 3 DOA Other; Nursin		idence 6 🗸 Other	r: Scene
ion of Vit tending Physic eath. tor: After this the funeral dire	tion: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury FOWND: Pay Year) FOWND: Day Y	Bb. Time of Injury 28c. Injury at Work? COUND: 1 Yes 2 ✔ No	28d. Describe how Subject shot se	injury occurred	
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 Could not be determined (Specify) Parking garage	e, farm, street, factory, office building, etc. ge	or Town, State 1203 Fidler Lane,	Silver Spring, MI	
To the Hos within 24 hd To the Fun completely	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, and for investigation, in my opinion, death occurred a 29c. License number	at the time, date and	and manner as stat place, and due to the	e cause(s)
	2	29b. Signature and title of certifier	O.C.M.E.		uly 9, 2009	nui, Day, I Gai)
MAH	ı.	 Name and address of person who completed cause of death (Item 23 Ana Rubio MD. Assistant Medical Examiner 11 	^{3a)} I1 Penn Street, Baltimore, MD 2120	1		
S Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	A. bake			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	Certificate of			. No.				
		1. Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death			
Physi /Med		Edna Naomi DeLoach			July	16 2009	9:50 A ^M			
Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	r Location of Death		4c. County of Deat	h			
		281 Chandlee Rd.		ng Sun		Ceci	.1			
Funera	al	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Monthe Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign ountry)			
Directo	r	210-10-4013	S		Mar. 19,	1923	Maryland			
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location				10d. Inside City Limits			
aryla sho	1						1 ∐Yes 2X No			
he M	tod	Maryland Cecil Risin 10e. Street and Number	g Sun 10f. Zip Code		100	. Citizen of What Co	untry?			
with t	ے ا	OCA CI II II DI			109		,			
sath is 23	Funeral Director	281 Chandlee Rd. 11 Marital Status 12. Was Decedent Ever in U.S.	219		ecify Yes or No-	USA 14. Race - Ame	rican Indian.			
ter de	2	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	 Was Decedent of H If Yes, specify Cuba 	an, Mexican, Puerto	Rican, etc.)	Black, White				
hours aft	2	If Yes, Give 3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2X No	Specify:		Specify: Wh	ite			
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ary and l	- [Mailing Address (Street	and Number or Rui	al Route Number, C	City or Town, State, 2	Zip Code)			
y Mand 2 and 2 salth 27 I			1 Chandlee							
es toth		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State	isposition (Name of crematory or other place	ce) 7-20-	Date 20 -2009	c. Location - City or	Town, State			
Page nent ant: I			ard Funera	1		ising Sun	, Maryland			
DESILITIOTE, INITIALITY STATES A LOCATOR permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Even invariant be neutred at	olice.	21. Signature of the all Service Licensee	22. Name and Addre		Home. P.	Α.				
n gore	ol	Just. M. Fr	<u> </u>				Augustinata			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	t enter the mode of dyli	ng, such as cardiac	or respiratory arres	τ,	Approximate Interval Between Onset and Death			
Physicia	_	Immediate Cause (Final disease or condition resulting in death)	cez				unknown			
/Medica	_	Due to (or as a consequence of)	:							
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Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit					1 ☐ Yes	2 □ No 3 □ P	robably 4 Tunknown			
law requires t as been signe	Completed				24a. Was an	24h Were a	utopsy findings available			
ne lav	8				autopsy performe	prior to death?	completion of cause of			
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VITAI sician; T certifica rector, p	8	examiner?	atient 3 DOA Oth	or:	th (Check only one)					
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tending death. for; Afte	į	1 ☑ Natural 5 ☐ Pending (Month, Ďay, Year) Inju 2 ☐ Accident investigation		rk̃?]Yes 2 □No						
deal deal ctory	100	3 Suicide 6 Could not be determined	n, street, factory, office		28f. Location (Stre	et and Number or R	ural Route Number,			
after after din b	Cartification	4 ☐ Homicide determined building, etc. (Specify)			City or Town,	State)				
To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached										
the H iin 24 the Fi	Modical	one) and manner stated.								
29c. License number					290	29d. Date signed (Month, Day, Year)				
		> Jackder 5 MD	1 900	23322		7/17/09				
3		30. Name and address of person who completed cause of death (Item 23a) (Ty	ype, Print) High St;	FOLT	mnai	001				
		S. S Sachdev MD, 126 A. E.	use st;	E-12 (m)	10 21	721,				
S Regi:	State strar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	and a							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** James E. Edwards, Sr. 4/1 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner RIVERSIDE 9. Birthplace (State or Foreign Country) CAM E If Under 1 Year | If Under 24 H 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Hours 1**火**□ M 2□ F Days 88 **Director** 12/01/1920 Virginia 226-16-3266 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits tems 23a or 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ⊈Yes 2 ☐ No Director MD Havre de Grace Harford 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Completed by Funeral 21078 U.S.A. 731 Tydings Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1√ Yes 2 □ No If Yes, Give WW II Year or Dates: WW II 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Monee. College (1-4or 5+) Civil Service Government Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Edwards. Jr. (Son) 2719 Ady Road. Forest Hill. MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/23/2009 Haure de Grace. MD Erin Cemeteru 21. Signature of Funeral Service Licens 22. Name and Address of Facility Zellman Funoral Homo. P.A. 123 S. Washington St., Havre de Grace. MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** heimfro /Medical Due to (or as a consequence of): Examiner Due to (or as a 2 nsequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Meter burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 D No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 DNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

within 2 To the I

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dilarose François July 13, 2009 4:25 p /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery
9. Birthplace (State or Foreign
Country) Silver Spring Holy Cross Hospital If Under 1 Yea 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Months 1 M 2 □ F 26, 83 Jàn. 219-15-4146 Haiti Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any luny or other traumatic event, If a Maries Examiner must be rediffied a once. 1 ☐ Yes 2 No Director Hyattsville Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 2106 Ravenswood Street 20782 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ♣ ♣ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Black <u>ک</u> 3 X Widowed 4 □ Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Francois ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ronald François/Son 2102 Van Buren Street, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 20, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2000 ²² Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part. Enter the efsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia **Physician** /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Pulmonary Fibrosis burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.0. been signed by the sahould be detached 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 sl autopsy performed? 1 ☐Yes 2 ☐No 1 Yes 2x5 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∏ Yes 2 Ho 2 ER/Outpatient 3 DOA 1 X Inpatient Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation after death.

Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral f 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who Adaku Onukogu, MD

(1500) Forest Glen Road, Silver Spring, MD 20910

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D65953

July 14, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 July 13, Alma Fore 10:45 a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Bethesda Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Aug. 26, 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) y Year) 5. 1913 Days Hours 1 □ M 2 🖺 F Months 215-03-0558 95 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10201 Gary Road 20854 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 CMio If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Manager Leather Goods Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Keenan Elizabeth M. Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adair LeMaster/Daughter 10201 Gary Road, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 💆 Other (Specify)entombment July 16. 2009 Timonium, Maryland 22 Name and Address of Facility 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature Funeral Service/Licens 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STAGE ND Due to (or as a consequence of): 3d. Date of delivery Month Day Year se contribute to the cause of death? TNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ So

29d. Date signed (Month, Day, Year)

7115109

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Examirer must be notified at

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of Health and Mental Hygis fitem 27 Is marked other or other traumatic event, In

Department of Important: If it any Injury or o

Director

Funeral

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Completed

Be

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with the Maryland

Pages 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit After this certificate has funeral director, page 2 s

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Truong Bao, MD 31. Date filed (Month Day

Medical

State Registra

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month Day Yea
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ★ 3 ☐ Probably 4 ☐ Unkn
	24a. Was an autopsy findings ava prior to completion of caus performed? 1 □ Yes 2 □ 10 1 □ Yes
25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Oth
27. Manner of Death 1 Adatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Sec. Injury at Work? M 1 Yes 2 No
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

zero, MA

32. Registrar's Signature

DHMH 17 Rev 1/2001

10110 Molecular Drive, Rockville, MD 20850

Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0057124

Drivin 17 Rev 1/2001 OCME 2006

State Registrar 32. Registrar's S

bnature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician July Day 2009 Ye ar Francis Harry 14, 6:20A. Gosman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14134 Brighton Dam Road Clarksville Howard 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Jan. 19, 1924 1 √ M 2 □ F Months Min. Days Hours Mary Tand 577-24-1388 85 Yrs Director Usual Residence of Decedent 10c. City, Town or Location Clarksville 10a. State 10b. County show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Maryland Howard Director 1 □Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21029 14134 Brighton Dam Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 XNo <u>ک</u> Specify: Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4or 5+) Self Employed Entertainment injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Gosman Hazel S. Grove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie F. Sullivan -Daughter 14150 Brighton Dam Road Clarksville, Maryland 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metropolitan Crematory 7/15/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 vones 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Protstate Cancer Stare IV disease or condition resulting in death) 10months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate course. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the hirrial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia: 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nasidence 6 Other (Specify) 2 XNo 1 ☐ Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030573 July 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Minford, M.D. 11065 Little Patuxent Parkway Columbia, Maryland 21044 31. Date filed (Month) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day 2009 Year **Physician** July 14, Hunt 9:40 pM Gonciarz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | April 16, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1923 Months 1 M 2 X Louisiana 86 435-26-7945 Director Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Evament a ust be notified at 1 ☐ Yes 2 ☐ No Director Rockville Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? USA 20853 13100 Parkland Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Wedfeal Evantment in that once. Quotes. Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WWII White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk Financial Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matt William Hunt Audrey McLamore ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13100 Parkland Drive, Rockville, MD 20853 Matt Gonciarz/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State July 17, 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 Donation 5 Dother (Specify) 2009 21. Signature of Funeral Service Licenses 22 Name and Address of Eachith ins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced Ovarian Cancer **Physician** /Medical Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 X No spital or Attending Physician: Theory after death.
neral Director: After this certificate y filled in by the funeral director, pa 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Marient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 624 hours a To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical and manner stated. 29c. License number D66182 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 14, 2009 Perres M. 5+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Hilary I. Ufearo, MD 1500 Forest G 1500 Forest Glen Road, Silver Spring, MD 20910 Year) 31. Date filed (Mont) 32. Registrar's Signature State 2009 parked Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Bryan buldberg J'U1-2059 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, Year 11/05/1959 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number $2\,18 - 8\,2 - 4\,2\,5\,1$ **Funeral** Min. 1 1 M 2 □ F Months Days Hours 49 Director Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner quest be notified at 1⊠Yes 2□No Director Gaithersburg MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a 20878 821 Inspiration Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 White 1 ☐ Yes 2 X No Specify. Specify. Completed by 3 Widowed 4 Divorced 'natural", d 2 should be filed within 72 ho th and Mental Hyglene. 7 is marked other than "natur. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Ronald Sanford Goldberg Sally Berman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 20854 8104 River Falls Dr, Potomac, Maryland Jodi Fields, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) King David Memorial Gardens Date 20c. Location - City or Town, State permit. Pages 1 and Department of He Important: If item any Injury or oth once. 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/16/2009 Falls Church, Virginia 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service M01163 1091 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Lesponatory disease or condition resulting in death) days /Medical Due to (or as a conseque ce of): Examiner STrolle Sequentially list conditions, any, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit mar MI Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 1 □ Yes 2 12/No ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🗆 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

COUNTRERS, BRYAN 4/14/09 2059 P.M. Division of Vital Records, P.O. Box 68760,

or A To the Hospital or within 24 hours at To the Funeral D

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mauro Sarmiento, MD, 8600 Old Georgetown Road, Bethesda, Maryland

MO

2009^{32. Registrar's Signature} 31. Date filed (Month, Day)

and manner stated.

Sarmiento

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D DD668995

29d. Date signed (Month, Day, Year)

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2009

			For State Registrar	State of Maryland		artment of He ertificate of E		/lental Hy	giene Reg. No.	2009	24473
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	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. In	ast birthday	-	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, D	th	9. Birt	thplace (State or Foreign
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	ryland how	_	10a. State 10b. County		, Town or L						10d. Inside City Limits
	he Ma 28a-f s	Director	Maryland Washingt	on County Hage	rstow	n 10f. Zip Code			10a Citiz	zen of What Co	1 X Yes 2 No
	3a or	al Dir	1137 Luther Dr.			21740)			.S.A.	dility:
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of His If Yes, specify Cubar		ecify Yes or No Rican, etc.)		4. Race - Ame Black, White	
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Maryiand	12 s h ar 7 is trau	0.9	19a. Informant's Name/Relationship (Doris J. Grumbine			ing Address (Street a. Luther Dr			-		Zip Code)
ā,	es t and of Health f item 27 r other tr		20a. Method of Disposition	20b. Pl		osition (Name of matory or other place		Date		cation - City or	Town, State
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X Q Q	death certific e attending p id for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnat		☐ Ectopic pregnancy			2	3d. Date of de Month	livery Day Year
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	hysician: The law his certificate has E I director, page 2 sl		25. Was case referred to medical				26. Place of Dear	1 □ Yes	2 -No	1 ☐ Yes	2 □ No
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5	ital or irs afte ral Dir led in	Cert	4 ☐ Homicide determined	building, etc. (Specify	') 			City or 10	wn, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical	29a. Certifier 1 Certifying PI (Check only one) 2 Medical Example 1	hysicían: To the best of my know miner: On the basis of examinat and manner stated.	wledge, dea tion and/or i	th occurred at the tim nvestigation, in my op	e, date and place inion, death occu	and due to the red at the time	cause(s) date and	and manner a place, and due	s stated. e to the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier			29c. License			29d. Date	e signed (Mont	th, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 15, 2009 12:30 P Griffin Bernard James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Woodland Court Oxon Hill 8. Date of Birth Dec. 19, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F 85 North Carolina 129-22-6176 Director Usual Residence of Decedent death with the Maryland 10a, State 10d. Inside City Limits 10b County 10c. City. Town or Location 28a-f show ral", or items 23a or 28a-f shov Expressive to ust be notliged at 1 ☐ Yes 2XXNo Prince George's Oxon Hill Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5412 Woodland Court 20745 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainer. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2KKMarried 1 ☐ Yes 2 XNo Specify. þ If Yes, Give Year or Dates: W II **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Griffin Bessie Gibson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5412 Woodland Court Almetia Griffin / Wife Oxon Hill, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 K Removal from Stat Calverton Nat'l. Cemetery 7/22/2009 4 ☐ Donation _ 5 ☐ Other (Specify) Calverton , New York 21. Signatur Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland ar 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a sonsequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? this certificate 2 □No 1 Yes 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5XXResidence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 1XX Natural 5 Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of cert

Registrar

State

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Robert Griffith			ate of M	1arylar	nd / De	epartr	ment of	Health	and	Menta	ıl Hygie			20	09 2	47
	Da	For State gistrar				Certif	icate of	Deam			2. D	ate of Death	. No.		3. Time of Deat	h
Physician/ Medical Examine	•	Decedent's Name (First, Middle Robert Jose	_{e,Last)} eph G	riff	ith 1	III					J.	onth 1y 11, 20	Day 09	Year	0127 hrs	
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Funeral	5	Social Security Number	6. Sex	7	. Age (In	yrs. last	birthday)	If Under Months		If Under:	Min.			Co	untry)	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Activate Examiner must be notified at once	- 1	21. Signature of Funeral Service	UVI	1	//		1 2	//Ω1 D	1.40	nchu	ra Rá	l Br	entwo	od MI		
	4	23a. Part I. Enter the disease,	or complicat	ions that c	aused the	e death.	Do not ente	the mode	of dying,	such as c	ardiac or r	espiratory ar	rest, shoc	k, or heart	Approximat Between C	
Physician ledical		failure. List only one caus	se on each i	_{ine.} ad and (Dea	ath
aminer	ļ	Immediate Cause (Final diseas or condition resulting in death)		to (or as a												
		Sequentially list conditions,	b													
	ner	if any, leading to immediate		to (or as a	a consequ	uence of):									
	Examine	(Disease or injury that initiated events resulting in death) Las	t Due	to (or as	a consequ	uence of):									
and and	al E		d	MENDED	#1	as n	oted	per M	E G8	94 8	/4/09	TT				
), be exi sician urial	dical	UNPENDED								_			23d	. Date of deliv	very	
Box 68760, e death certificate b the attending physied for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant in		23c. If yes,		or pregr	2	Fetal death	3	Ectop	ic pregnan	ісу		Month	Day	Year
c 68 certil	cial	past 12 months?		4 Preg	nant at ti	me of de	ath 5	Other (Spe	ecify)				22			
Box death	ıysi	1 Yes 2 No 9		9 Unkı		_		at a state day		given in F	Port I	23e. Dio	tobacco u	use contribute	e to the cause of	death?
, P.O. Box 68760, rres that the death certificate be ex signed by the attending physician 1 be detached for use as the burial-	y Phy	Part II. Other significant con	ditions co	ontributing	to death I	but not re	esulting in t	ne unaenyin	g cause	giverini	ait i.			No 3	page-1-14	Unknown
s, P	ed by											24a. Wa	as an	24b. Wer	e autopsy finding	s available
ords,	Completed											pe	topsy rformed?	deat		
tal Reco cian: The law certificate has	mo											1 ✔ Ye	s 2 N	o 1 🗸	Yes 2	No
Vital Rec ysician: The I his certificate I	O)	25. Was case referred to med		mital:			1			Other	h (Check o	g Home 5	Reside	ence 6 🗸 C	Other: Scene	
Vita hysici this c	O B	examiner? 1 ✓ Yes 2 No		spital: 1	Inpatier		ER/Outpat		DOA 128c Ini	ury at Wo	-t/2 T	28d Describ	ne how init	irv occurred		
n of Vi ling Physi After this	T:U	27. Manner of Death 1 Natural 5		FOUN	te of Injur hth, Day,Ye ID:	y par)	FOUND		i	Yes 2		Motorcycl	ist in cy	cle/fixed o	object collision	'n
tend tend death.	atic		Pending nvestigation	. Lut 11	2009		0127 hrs nome, farm,	street facto			etc.	28f. Locatio	n (Street a	and Number o	or Rural Route N	umber, City
Division of Vital Records, tall or attending Physician: The law requires after death. After this certificate has been sind birector: After this certificate has been sind in by the funeral director, page 2 should the	Certification:		Could not be determined	28	y) Loc			311 001, 10010	,,			or Tow Route 3 &	n, State) Route 42	4, Crofton,	MD	
Dospita hours neeral y fille		4 Homicide				Jennedos	dee death (occurred at t	ne time,	date and	place, and	due to the c	ause(s) ar	nd manner as	stated.	
Division To the Hospital or Attendiv within 24 hours after death to the Funeral Director. A completely filled in by the fin	Medical	(Check only one) 2 Medical	Examiner: C	on the basi	is of exan	nination	and/or inves	stigation, in	ny opini	on, death	occurred a	at the time, d	ato and pi	400, 4114 411		
To t with To t	Med	29b. Signature and title of ce	a	ind manne	stated					nse numb			29d.	Date signed	(Month, Day, Ye	ar)
	-	1/1/11/11/11	1200	11					0.0	C.M.E.			July	y 11, 2009		
		30. Name and address of pe	rson who co	mpleted 6	ause of d	eath (Ite	m 23a)									
CR 10		Laron Locke MD.	Assista	ınt Medi	cal Exa	aminer	111 P	enn Stre	et, Bal	timore,	MD 212	201 				
S	itat		69	32.	Registra	Signa	ace									
Regis	417	A SELL T O EV	/													

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

		For State		State of	f Marylan		partment of			ental Hy		2000	3 /	01.1.74
		Registrar 1. Decedent's Name (Firs	t Middle Lee	*1			ertificate of	Deam		2. Date of De	Reg. No.	2003	<u> </u>	3. Time of Death
Physicia /Medic		GILBERT		ASS	SR.					July	Day 7	y 200	r	9:45 p M
Examin		4a. Facility Name (If not in	nstitution, give	street and nur	mber)		4b. City, Town,	or Location	of Death		4c.	County of De	ath	
		Bel Pre Nu					Silver					lontgom		
Funeral Director		5. Social Security Number 431-82-727	4.1	ex 2X M 2 □ F	7. Age (In yrs.) 59	last birthday Yrs.	Months Days		Min.	8. Date of Bir (Month, Di Jan • 1	rth ay, <i>Year)</i> 7, 1	950 A	Birthplac Country R	ce (State or Foreign ')
>		Usual Residence of Dece	dent County		100 City	Town or I	antian						100	. Inside City Limits
shov	٦		,			y, Town or L							100.	1 ☐ Yes 2 ☒ No
8a-f	Director		ontgome	ery	S1	lver	Spring				10- 04	inon of Milant		
De d		10e. Street and Number					10f. Zip Code					izen of What (Journay	· f
s 23;	eral	2601 Bel P	re Kd.	10 Wes Deep	edent Ever in U.	6 10	2090		rigin? (Coo	oifu Vo o or Na		JSA 14. Race - Ar		Indian
Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examinet must be notified at once.	Funeral	11. Marital Status1 ☐ Never Married 2	TY Marriad	Armed Fo	rces?	5.	. Was Decedent of If Yes, specify Cu	ban, Mexica	an, Puerto I	Rican, etc.)	,-	Black, Wh		
l', or	by F	3 ☐ Widowed 4 ☐ D		If Yes, Giv	ve 1969	70	1 □Yes 21X No	Specify Specify	<i>/</i> :			Specify:	Bla	ck
atrua	pa		ecedent's Edi		_19	70 16a. Dec	edent's Usual Occi	upation			16b. Ki	ind of Busines		
n di	Completed		ly highest grad	de completed)	Acr.F.\	(Giv life.	e kind of work done DO NOT use retir	e during mo ed)	st of workir	ng	-			
r tha	E	12th	(0-12)	College (1	-401 5+)	Labo	rer				Var	ious C	omp	anies
othe	Be C	17. Father's Name (First,	Middle, Last)					18. Moth	ner's Name	(First, Middle	, Maiden	Surname)		
Aenta rked tic ev	ToE	John Herbe	rt Gla	SS				Vera	a B il l	lingsle	y			
s ma	-	19a. Informant's Name/R	elationship (7	ype. Print)		19b. Mai	ling Address (Stree	et and Numl	ber or Rura	l Route Numb	er, City o	or Town, State	, Zip C	ode)
alth 27 is	. 8	Sheila Gla	ss-Wife	е		3321	Hayes St	t. I	Lanhar	n, Md.	207	706		
e de la la la la la la la la la la la la la		20a. Method of Dispositio			1 0	lace of Disp	position (Name of ematory or other pl	ace)	D	ate	20c. Lo	ocation - City	or Town	n, State
nt: If		1 XBurial 2 ☐ Crei 4 ☐ Donation 5 ☐ C			State	-	Nationa	- i	7-15-	2009	Tria	angle,	VA.	
oorta Porta		21. Signature of Funeral			Qui		22. Name and Add							
9 1 2 3		Deres	C-6	Sla	Telm		308 Suit					1d. 207	46	
	3	23a. Part 1. Enter the disc										,	A	pproximate nterval Between
ysician	, ,	shock, or heart failu Immediate Cause (Final	ire. List only o	ne cause on e	ach line.	5,00	LACAE							nset and Death
Medical		disease or condition resulting in death)		a. Due to (or as a consequ	uence of):	MOSIS	^					+	
aminer					HERK	TOYF	MULA	R	CAR	CINS	MA			
	je.	Sequentially list condition if any, leading to immedia	s, te	b Due to (or as a consequ	uence of):			- / \ \	01. 0			+	
ansit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	1	C										
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endir use	Physician/Me	IF FEMALE: 23b. Was decedent pregr	iani		come of pregna		□ Ectonic progna	201				23d. Date of	delivery	
e att	icia	in the past 12 month 1 ☐ Yes 2 ☐ No	ns?	4 🔲 Pregi	birth 2 ☐ Feta nant at time of d		☐ Ectopic pregnar☐ Other (specify)					Month	Da	ay Year
by th	hys	9 ☐ Unknown		9 ∐ Unkn	own									
gned e del	by P	Part II. Other significant	conditions co	entributing to de	eath but not resu	ulting in the	underlying cause g	iven in Part	I.	23e. Did	tobacco ı	use contribute	to the	cause of death?
en si										1 🗆	Yes 2	□ No 3□	Probab	oly 4 Unknown
s sho	Completed									24a. Was				y findings available
age age	E									auto perfe 1 □ Yes	ormed! 2 Z No	death		iletion of cause of
rtifica tor, p	a l	25. Was case referred to	medical					26. Plac	ce of Death	(Check only		/ 101	55 2	
is ce direc	.o B	examiner? 1 ☐ Yes 2 € No		Hospital: 1 □ I	Inpatient 2 🗌	ER/Outpati	ent 3 DOA	ther: 4 X	Nursing Hor	ne 5∐Res	idence	6 ☐ Other (S	pecify)	
ter th	اڃَ	27, Manner of Death	10 "	28a. Date	of Injury th, Day, Year)	28b. Time Injury				28d. Describe				
ath. r:Af	atio	1 Accident	Pending investigation	(IVIOII)	in, Day, rear)	injury		∐Yes 2□	□No					
ecto by th	iji j	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	Zoe. Flace	of Injury - At ho	me, farm, s	treet, factory, office		2	28f. Location City or To	(Street ar	nd Number or	Rural F	Route Number,
s afte	Certification:	4 Difference		Dulla	ng, etc. (opecin	,,				Ony or ro	m, orac	-/		
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical (iner: On the b			ath occurred at the investigation, in my							
within To the comple	Med	29b. Signature and the of	certifier	(2)	/		29c. Licer	nse number	10		29d. Da	ate signed (Mo	onth, Da	ay, Year)
		30. Name and address of	person who	completed caus	se of death (Item	1 23a) (Tvne	e. Print)	51.	313			1114	10	1
6		31. Date filed (Month, Day	DA	Æ	9055 legistrar's Signa	ch	evelol-	ef	driv	e El	1100	If city	er	2(043
Sta Registr	_	JUL 1 6 200		32. H	d. Au	Ver 1				1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit P.O. Box 68760. Division of Vital Records. After this

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jacquelyn Marie Gunning 2009 10:00 A M July 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 107 St. Andrews Road Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 😾 F 82 Months Days Hours 213-28-9207 Director Oct. 07,1926 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaminer must be notified at any Injury or other traumatic event, the Medical Evaminer must be notified at ange. 10a. State Anne Arundel Severna Park Funeral Director 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 107 St. Andrews Road 21146 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 ▼No
If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🔀 No Specify: Be Completed by Specify: White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Friedel Lillian McCourt ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Kris Gast / 670 D Street Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from S Arlington, VA 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Part 1. Enter the disease, or com shock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** month ancar dder /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Be Completed by Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 2 D Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation ours after death.

leral Director: A
filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) ature and title of certifier 29d. Date signed (Month, Day, Year) Veterans Hwy Millersville Min 30. Name and addressrof person who completed cause of death (Item 23a) (Type, Print) State

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of Marylan	•	artment of Health rtificate of Death			ene J. No. 2000	21.1.79
2	Physicia	212	1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	3. Time of Death
	/Medic		Bertha S. Ga					uly 10,	2009	10:15 P ^M
	Examin	er	4a. Facility Name (If not institution, give s	,	h	4b. City, Town, or Location	of Death		4c. County of Death	r
, poli			South River Health 5. Social Security Number 6. Sex			Edgewater	er 24 Hrs. 8.	Data of Birth	Anne A	
	Funeral Director		036-10-2427	м 2 Д F 91	Yrs.	Months Days Hours	Min.	Date of Birth (Month, Day,)		place (State or Foreign htry) Sachusetts
	land ow		10a. State 10b. County	10c. City	, Town or Lo	cation			1	0d. Inside City Limits
	Mary a-f sh	ctor	Maryland Anne Aru	nde1	Edgewa	ater				1 ∐Yes 2 🛣 No
	or 28	Director	10e. Street and Number		2080	10f. Zip Code		100	g. Citizen of What Cour	itry?
	23a	ral	1407 Shore Drive			21037			USA	
	tems	Funeral	11. Waltar Status	2. Was Decedent Ever in U.S Armed Forces?	3. \ 13. \	Was Decedent of Hispanic C f Yes, specify Cuban, Mexica	origin? (Specif an, Puerto Ric	y Yes or No- an, etc.)	14. Race - Americ Black, White,	
900	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Modeol Exprainer must be ceithed at	by	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ∐Yes 2 MM No If Yes, Give Year or Dates:		1∐Yes 2 X ∏No <i>Specif</i>	y:		Specify: Wh	ite
5	72 h "natu	lete(15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupation kind of work done during mo	st of working	16	6b. Kind of Business/Inc	dustry
12	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) Homemaker			Home	
d 2	filed I Hygi other ent,	Be C	17. Father's Name (First, Middle, Last)				her's Name (F	irst, Middle, Ma	aiden Surname)	
rylan	d Menta narked natic ev	To B	George Szaldak	Division of the second	1 401 44 75			ne Sien		
Ma	d2sh Ithan 17 Isr traur		19a. Informant's Name/Relationship (Type Frederick F. Galer	· ·	1	ng Address (Street and Num. Shore Drive,				(Code)
ē,	tem 2		20a. Method of Disposition			sition (Name of natory or other place)	Date		Oc. Location - City or To	wn, State
OE I	Pages lent o nt; If i		1 XBurial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State _		Men 1. Gardens	7/17/0	79 1	Lexington,	Virginia
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Model Examiner must be rediffed at once.		21. Signatur Purieral Service License		22	. Name and Address of Faci	Georg	ge P. K	alas Funera	al Home
	-		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death		973 Solomons er the mode of dving, such a				Approximate Interval Between
S.	Physician	1	Immediate Cause (Final	e cause on each line.	dess. t	1 Gent	disc	2	from 1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):	ic heard		* acl	1 areas	
	Examiner		Coguantially list conditions				100	Macco	Curr	
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	rerice of).					
	xecuti and I-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of).					
68760,	tificate be executed g physician and as the burial-transit	alE		240 10 (0) 40 4 00110040	101100 017.					
687	ificate g phys	edical	d.							
		In/M	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregna		15			23d. Date of delive	ery
P.O. B	Physician: The law requires that the death cer this certificate has been signed by the attendir ral director, page 2 should be detached for use	Physician/M	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown		Sctopic pregnancy Other (specify)	**		Month	Day Year
<u>. </u>	law requires that the di as been signed by the 2 should be detached		Part II. Other significant conditions con	tributing to death but not resu	Iting in the ur	nderlying cause given in Part	t I.	23e. Did toba	cco use contribute to the	ne cause of death?
Division of Vital Records,	quires en sigi uld be	ed by						1 ☐ Yes	2 No 3 Prob	pably 4 ☐ Unknown
oca	e law re has be e 2 sho	Completed						24a. Was an		psy findings available
Œ.	nysician: The nis certificate h director, page	Com						autopsy performe 1 □Yes 2	death?	mpletion of cause of
/ita	ician: The certificate ector, pag	Be (25. Was case referred to medical examiner?				ce of Death (C	Check only one)		
_	Physi this c		1 Yes 2 No	ospital: 1 Inpatient 2					ce 6 ☐ Other (Specif	y)
u o	ding F	ion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □		I. Describe how	injury occurred	
isi	or Attencafter death	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre			Location (Stre	eet and Number or Rura	al Route Number.
<u>S</u>	al or s after I Dire	Certification: To	4 Homicide	building, etc. (Specify	<i>'</i>)	•		City or Town,	State)	,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier Check only one) Certifying Phys	ician: To the best of my knowner: On the basis of examination and manner stated.	wledge, death tion and/or in	n occurred at the time, date avestigation, in my opinion, de	and place, and eath occurred	d due to the cau at the time, dat	use(s) and manner as s e and place, and due to	stated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier			29c. License number		290	d. Date signed (Month,	Day, Year)
	. , , ,) lau	~ MI)	00053	3709		July 13,	2009
0	11.1		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type,					
B	Sta	10	Raj K. Chawla, M. 31. Date filed (Month, Day, Year)	32. Begistrar's Signat	ture	Tallant	1.04	In	50001	€ MO
	Sta Registr		JUL 15 20	09 Drews	B. 1	are				20715

09-05729 Robert Honner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ррец норрег		State of Maryland / Department of Health and Mental Hy For State Certificate of Death	Reg.	No OO	00 0117
Physician	_	gistrar	2. Date of Death		3. Time of Death
ledical Examine	er	Robert Wayne Hooper	Month D July 22, 200	9	0559 hrs
	4a	. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Union Hospital Elkton		4c. County of Deat Cecil	h
Euparal	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9. Bi	
Funeral Director		216-78-5309 1XM 2F 48 Yrs. Months Days Hours Min.	Septembe	r 21,1960 Fore	gn Maryland ountry)
any	-	a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
* ·	⊾ M	aryland Cecil Elkton			1 Yes 2 X No
the Maryland a or 28a-f show iffied at once.	10	le. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
ith the Maryland 23a or 28a-f sho notified at once		600 Bouchelle Road, #1 21921		USA	
or items 23	16 11	. Marital Status 12. Was Decedent Ever in U.S. Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Cuban, Mexican, Puerto Forces)		14. Race - Ame White, etc.	rican Indian, Black,
er death		Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Wh	ite
urs afi tural'	<u>6</u> —	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wi		6b. Kind of Business	/Industry
5 72 ho 72 ho 111 "na 12 Ex		Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retire	ed)		
5-0036 led within 72 hours after Hygiene, other than "natural", the Medical Examiner		12 Route Salesman Father's Name (First Middle Last) 18,Mother's Name	/E Middle Ma	Portable	Storage
D 21215-0036 Should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shreatic event, the Medical Examiner must be notified at once TO Be Completed by Eumoral Director	2 17 8 8	Tallor of tallor (1 mod modern)	therine		
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MD dd 2 shou ulth and m 27 is a sumatic		Brandy F. Hooper / Daughter 5309 Riverdale Road,			
re, S I an f Hee If ite		Da. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	or Town, State
imo Page nent o ant; or oth	4	Donation 5 Other Specify: Fort Lincoln Cemetery 7/2	29/2009	Brentwood	l,Maryland
Baltimore, permit. Pages I ar permit. Pages I ar Department of Her Important: If ite injury or other tr	21	I. Signature of Funeral Service Licensee 22. Name and Address of Facility	D 4	739 Balti	more Avenue
Physician	12	Gasch's Funeral Home Sa. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Inmediate Cause (Final disease a. Atherosclerotic cardiovascular diseas			Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the thineral director, page 2 should be detached for use as the burial-transit	<u> </u>	X UNPENDED AMENDED 23a,P11,2/,perME, g894 8/ 10/0)9 TT		
60, ate be hysici te buri	₩ IF	FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ery
687 certific ding p	231	b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnal	ncy	Month	Day Year
Box 687: death certific: the attending ped for use as the	Physician/	Yes 2 No 9 Unknown 9 Unknown 9 Unknown			
that the d the by the detached	E P	art II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
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Vital Recysician: The lability of the director, page	99 25	5. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other, Nursin			
Division of Vital Records, tall or Attending Physician: The law require started cleath. al Director: After this certificate has been sited in by the funeral director, page 2 should be difficultion. To Bo Commissions	٥	1 V Yes 2 No	J	tesidence 6 Oth	ner:
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r Atte rer dea irector n by th	2 Z	28e Place of Injury - At home, farm, street, factory, office building, etc.			Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:	determined (Specify)	or Town, Sta		
Division of To the Hospital or Attending Physicial or Attending Physician 24 hours after death. To the Fameral Director: After To ompletely filled in by the function or After	1 29	Ba. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a	due to the cause	(s) and manner as st	ated.
To the within 7 To the complet	Medical 29	and manner stated. 29b. Signature and title of certifier 29c. License number	it the time, date a	29d. Date signed (A	
	2 2	O.C.M.E.		July 22, 2009	ionin, boy, rowy
	30	Name and address of person who completed cause of death (Item 23a)		·	
S	30	Larpn Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	01		
Stat	te 3°	1. Date filed (Month, Day, Year) 32. Registrar's Signature			
Registra	ar	JUL 2 7 2009 Lane B. Marce			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Juanita Hill Ju₁y 2009 12:00 P.M 14, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's 9413 Juliette Drive Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 08/03/1936 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🛚 F 72 Director PA <u>175–30–0748</u> Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shov Director 1 X Yes 2 □ No MD Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9413 Juliette Drive 20735 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify: Black 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, I and once. Elementary/Secondary (0-12) College (1-4or 5+) Print Shop Manager Church 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Gethers Rose Banks 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise N. Ross/Daughter 9413 Juliette Drive, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 07/17/2009 Chesapeake Beltsville, MD 22. Name and Address of Facility Strickland Funeral Services 21. Si nature of Funeral Service Licens rulla 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Malignant carcinoid tumor small intestine years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) Examine law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Year Day signed by the a d be detached for 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform 1 □Yes 2 No Division of Vital 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28d. Describe how injury occurred al or Attending F s after death. 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled in ! within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) DC-18561 07/16/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David J. Perry, 110 Irving St., NW, Washington, DC 20010 32. Registrar's Signature 31. Date filed (Month. Day State JUL 1 7 2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05672 State of Maryland / Department of Health and Mental Hygiene Ronald Jerry Hymes 1- For State Certificate of Death Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle, Last) Physician/ 0537 hrs July 20, 2009 Medical Examiner Ronald Jerry Hymes 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Hyattsville 5600 Hamilton Manor Drive Apt. 6 If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours Country): Director 59 11/23/1949 1 X M 2 Yrs 579-64-1514 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No s 23a or 28a-f show s notified at once. 28a-f show PRINCE GEORGE'S Hyattsville MD- MA with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 5600 Hamilton Manor Dr. Apt. 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status items 2 Armed Forces? death v 1 Never Married 2 X Married 2 X No Yes Specify: Black Yes 2 X No specify: If Yes, Give Year Widowed Divorced 3 ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 Pages 1 and 2 should be filed within 72 Pages 1. If item 27 is marked other than ' her traumatic event, the Medical Baltimore, MD 21215-0036 years Manager 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Dyer Be or other traumatic event, James Hymes, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2909 Olivine Way, Silver Spring, MD 20904 Ann Hymes/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place)
National Harmony
Memorial Park Removal from State 1 X Burial 2 Cremation 3 tment o 7/29/2009 Largo, MD Other Specify Donation 5 22. Name and Address of Facility Marshall's Funeral Home ature of Funeral Service Licenses 4217 9th St NW Washington DC 20011 Approximate Interval Between Onset and Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Physician failure. List only one cause on each line. Death /Medical Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit AMENDED 23a, PII, 27, perME, g893 7/31/09 TT Physician/Medical X UNPENDED Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Fetal death Live birth past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Vunknown ğ Pancreatitis; sleep apnea Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Other₄ examiner? Hospital: 1 Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 🗸 Yes No ٩ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier DOME July 20, 2009 O.C.M.E.

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Yes

Theodore M. King, Jr., MD.

ORIGINAL

111 Penn Street, Baltimore, MD 21201

who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

DHMH 17 Rev 1/2001

09-05415 Joseph Hudson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 009 24482 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month July 10, 2009 1958 hrs HUDSON JOSEPH Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Bayview Medical Center If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Davs Hours Months Director 08-27-1996 WASHINGTON, DC 1X M 2 579-27-9189 12 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County X yes 2 No 28a-f show or items 23a or 28a-f shows and be notified at once. BALTIMORE Director 10q. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21206 5004 GOODNOW RD 14 Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No BLACK Yes 2 X No specify: Specify: Pages I and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. Aunti: If iten 27 is marked other than "natural", o mar it file tent and the transmitter event, the Medical Examiner in other traumatic event, the Medical Examiner in f Yes. Give Year 4 Divorced Widowed ð Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE Baltimore, MD 21215-0036 STUDENT 7th Com 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) JUNIOR HUDSON JAMELL DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5004 GOODNOW RD BALTIMORE, MD 21206 JAMELL DAVIS/MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07-21-2009 LANDOVER, MD HARMONY CEMETERY rtant: Donation 5 Other Specify: 22. Name and Address of Facility JB JENKINS FUNERAL HOME Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line 'V. dical Death a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury mai initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial -P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Day 3 Ectopic pregnancy Month Year Fetal death Live birth Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 signed by the a detached fo Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Probably 4 Unknown Yes 2 ✔ No 3 Completed Records, 24a. Was an 24b. Were autopsy findings available certificate has been sector, page 2 should prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes No page 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other₄ Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Jul 10, 2009 28b. Time of Injury 27. Manner of Death Pedestrian struck by auto Certification: 1930 hrs Natural Yes 2 V No Director: Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Northpoint Road @ Eastern Avenue, Dundalk, Md. Suicide determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier July 12, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day Year 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

State

DHMH 17 Rev 1/2001

Registrar

SATHIEEN

S. PACA

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32. Begistrar's Signature

Baltimore, MD 21301

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSTEllo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July **Physician** 13, 2009 Khafizova 2:20 P M Maryam /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 435 Christopher Avenue, #11 Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗷 F Months Days Hours Director 214-73-5858 May 14, Uzbekistan Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f st Exandrar mast be notified 1 X Yes 2 □ No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 Uzbekistan 435 Christopher Avenue, #11 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examinat 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 TYes 2 No Specify: \$ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DNA Laboratory 5+ Biochemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gabdulbari Khafizov Yasira Nizametdinova ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniyar Seyfullin - Son 8802 Swallow Court, Gaithersburg, Maryland 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State J 07/20/2009 4 Denation 5 ☐ Other (Specify) Fort Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility 21. Si nature o Funeral Service Licensee Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition resulting in death) **Physician** Stomach Cancer /Medical Due to (or as a consequence of): Examiner Cancer Metastatic to Peritoneum Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Hospital or Attending Physician: The law requires that the death certificate be each hours after death.
 Funeral Director: After this certificate has been signed by the attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? Month Day Year ☐ Pregnant at time of death 5 Other (specify) ned by the a detached f 2 🗷 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🔼 No 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 29a. Certifier 🛮 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Werman D0052832 July 15, 2009

Registrar
DHMH 17 Rev 1/200

State

31. Date filed (Month, Flay

Irina B. Sherman, M.D., 1396 Piccard Drive, Rockville, Maryland 20850

32. Registrar's Signature

record

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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-	-	For State Registrar			State	או ועוכ	ai yiai ii		rtificat			-	Reg. No	000	0	21.1.05
		Decedent's Name	e (First, Midd	le, Last))				-			2. Date of De	ath		-	3. Time of Death
Physicia /Medic	_	Irene '	Thelma	Kir	nzer							Month	Da 1		78	800 AM
Examin		4a. Facility Name (I	If not institutio	n, give	street and n	umber)			4b. City,	Town, or	Location of Deatl	h	40	. County of D		
/		Washingto							Milada		gerstown	T = 1 (5)		Washir		
Funeral Director		5. Social Security N 219-05-0		6. Sex	x]M 2 X ∫F	7. Ag	e (In yrs. I 91	ast birthday, Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov • 24	, 191	7 Pe	Cour Pnn	lace (State or Foreign sylvania
pur 🖈		Usual Residence of 10a. State	f Decedent 10b. County	,			10c City	v. Town or Lo	ocation			-			1	0d. Inside City Limits
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ould b Meniarked arked	2	Charles						1			Mary			Sun		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inpopratment of Health and Mental Hygiene. Inpoprant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evant her must be notified at once.		19a. Informant's N. H. Duane				W					and Number or Ru timore S					
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Atten r deat ector: by the	ifica	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could	not be	28e. Plac	e of Inju	ury - At ho	me, farm, st	reet, factor			28f. Location	Street a	and Number of	r Run	al Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. The The Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the temperature.	Medical	29a. Certifier (Check only one)				basis o	f examina				me, date and plac opinion, death occ					
To the transfer of the transfe	Ž	29b. Signature and	title of certifie	er							e number		29d. D	ate signed (M	onth,	Day, Year)
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			For State Registrar	State of Maryland	-	rtment of H <i>tificate of L</i>		lental Hygie Reg.	0000	21.1.86
	Physici		Decedent's Name (First, Middle, Last Emile	Lymber	tos			2. Date of Death July 14	Pay2009 ^{ear}	3. Time of Death 11:25a _M
nda yan	/Medic Examin		4a. Facility Name (If not institution, give Shady Grove A			4b. City, Town, or Rockv	Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. S		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign Intry) Yria
	Maryland -f show	tor	Usual Residence of Decedent 10a, State 10b, County MD Montgo		Town or Loc aithe	ation rsburg				10d. Inside City Limits 1X Yes 2 □ No
	3a or 28a	Funeral Director	10e. Street and Number 5 Longmeadow	Drive		10f. Zip Code 208	78	10g.	Citizen of What Cou	intry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funera	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 2 Year or Dates:		/as Decedent of H Yes, specify Cuba ☐Yes 27 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Ye's or No- Rican, etc.)	14. Race · Amer Black, White, Specify: Wh	
Baltimore, Maryland 21215-0036	within 72 ho jene. r than "naturi the Medical i	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give k life. D	ent's Usual Occupi ind of work done of O NOT use retired ontracto	luring most of work i)	ing	construc	
land 2	ild be filed fental Hyg rked other lic event,	To Be C	17. Father's Name (First, Middle, Last) Nicolas Lymber	tos				e (First, Middle, Mai i Munira	_{den Surname)} a Abadji	
, Mary	and 2 shousalth and N 27 is maser trauma		19a. Informant's Name/Relationship (** Liza Lymbertos	ype.Print) /Wife	19b. Mailing 5 LC	g Address (Street ongmeado	and Number or Rur DW Drive	al Route Number, C Gaithe	ity or Town, State, Z rsburg, M	a. 20878
imore	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation ☐ Other (Specify	Removal from State ROC	ace of Dispos metery, crem CK Cr	ition <i>(Name of</i> atory or other plac eek cem	e) 7/17	I .	ashingto	
Balt	permit. Depart Import any inj		21. Signature of neral Service Ligen	The sulf	Pi 92	Marren Production Address Addr	RTNALDI umbia Bl	FUNERA vd.Silv	L SERVIC er Sprin	E,P.A. g,Md20910
Luig	Physician	8 4	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death. one cause on each line. Renal fail		r the mode of dyin	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical Examiner	L	resulting in death) Sequentially list conditions,	Due to (or as a consequence) b. Liver fail	ure					
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hepatitis Due to (or as a consequence) Due to (or as a consequence)	С					
O. Box (that the death certific hed by the attending p detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date of deli Month	very Day Year
rds, P.	es be	þ	Part II. Other significant conditions c	ontributing to death but not resul	ting in the un	derlying cause give	en in Part I.	0.1	cco use contribute to	the cause of death? obably 4XI Unknown
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ΖĦ	sicial certii recto	Be	25. Was case referred to medical examiner?	Hospital:		Othe	Dr.	h (Check only one)		
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Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, stre		Yes 2 □No	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	the Hospi iin 24 hou the Funer ipletely fill	Medical		ysician: To the best of my know niner: On the basis of examinati and manner stated.						
	3	Σ	29b. Signature and title of certifier	dare. , n	מר	29c. License	e number 67512	29d	July 14	
				alore M.D. 9	901 M	edical	Center 1	Dr. Rock	ville,Mo	20850
	Sta	te	31. Date filed (Month Day, Year)	2009 32. Registrar's Signati	ireg.	arked				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 8:55 a M Bobby G. Looney July 10 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arcola Nursing Home Silver Spring Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days 1 X M 2 □ F Yrs. Virginia Director 217-36-5528 70 March 2, 1939 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show up or other thanmal ke inoffled at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🛣 No Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 U.S.A. 901 Arcola Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 □Yes 2 No \$ Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Porter 9 Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Edna Thomas** Gallie Looney ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Hungerford Drive, Rockville, Maryland 20850 Fiona Graham - Guardian Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 07/17/2009 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 21. Signature of Funeral Service Licensee Edmonston Crossing Shopping Center, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 🗷 No 2 No 1 □Yes 1 Tyes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Phours after death.
neral Director: After ty filled in by the funera After Division Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D52261 July 10, 2009 ega 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Segal, M.D., 1517 Hugo Circle, Silver Spring, Maryland 20906 32. Registrar's Signature 31. Date filed (Month, State Registrar Kneura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
PI line b per MF G895 9/10/09 TT
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 LEWIS SHIRLEY J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Trince Laur regiona HOS 1017 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Ars. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🗘 F WASH. FEB. 5, 1944 D.C. 65 Director 220-42-4203 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examinal roust by retiffed at 1 X Yes 2 ☐ No Director SILVER SPRING MD. MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with U.S.A. 20910 1610 SOUTH SPRINGWOOD DR. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) PUBLIC SCHOOL **SECRETARY** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THOMPSON DOROTHY WILLIAM REID 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SOUTH SPRINGWOOD DR., SILVER SPRING, MD. 20910 DARREL T. LEWIS/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY: 7-16-2009_ RIVERDALE, MD. once. 21. Signature of Funeral Service Ligensee FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or # a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed thours after death. Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 🗌 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Because 27. Manner of Death 28b. Time of injury A 10:10 M 28c. Injury at Work? 1 Natural 5 Pending investigation Ay 13, 2009 Place of Injury - At ho building, etc. (Specify 1 □Yes 2 ☑No 2 Accident Los tion (Street and Number or City or Town, State) 6 ☐ Could not be 3 Suicide At home, farm, street, factory, office s wimming filled in by 4 Homicide PARK + Aquestic Ce To the Hospital c within 24 hours af To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Year

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) ule City, Town, or Location of Death ounty of Death cility Name (If not institution, give street and number) Age (In yrs. last birthda) 8. Date of Birth (Month, Day, Year) Birth Months Days Hours Min 1 □ M 2 🗓 F Yrs. 087-32-5296 79 03-06-1930 Korea Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No New York New York 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 75 Baxter Street 10013 USA 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give 1 Never Married 2 Married 1 □ Yes 2 No Specify: Korean 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Choon Woo Lee Kum Yi Yoon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wendell Louie/son 75 Baxter St., #30, New York, New York 10013 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 07-18-2009 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary Cedar Hill FH, 4111 PA Ave., Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Neutropenia resulting in death) Due to (or as a consequence of): End Stage Renal Disease Sequentially list conditions, if any leading to finite data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Alla to (or as a nonsequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗗 No 2 No 25. Was case referred to medical examiner? v 26. Place of Death (Check only one) 1 Tes 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Pesidence} \) Residence \(6 \) Other (Specify) X☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Physician /Medical Examiner Examiner

Physician

/Medical

Director

Funeral

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

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Department of Health ar
Important: If item 27 is
any injury or other trau

Pages 1 and 2 should be

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and attending physician the use as detached for ģ signed certificate this

Physician/Medical

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Certification: To

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funeral director, page 2 should be After n 24 hours after death. e Funeral Director: Af

completely within 2. 5

29a. Certifier 🞢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numb 29b. Signature and title of certified 30. Imme and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD 20850 Shahryar Davari, 31, Date filed (Month, Day, Year) 32. Registrar's Signature THE I DEMAN

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2020 artene 009 11-/Medical Facility Name (If not institution, give street and number), 4b. City, Town, or Location of Death Examiner Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year **Funeral** Days 1 ☐ M 2 1 F Months Hours Yrs. Director Usual Residence of Decedent 10a. State 10b. County City, Town or Location 10d. Inside City Limits 10c show oortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Evaminer must be notified at 1 ☐ Yes 2 No Director runde asaden 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 21122 Funeral within 72 hours after death Was Decedent Ever in N.S. Armed Forces? 1 □ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ۾ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed withi lealth and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ara ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route-Number, City or Town, State, Zip Code) of Health a item 27 is mother YI CI 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o Glen Haven Cemetery 7/16/09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License 851 Annapolis Road Gambrills,MD 21054 Hardesty Funeral Home P.A. atai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HY 3min **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leafing triminal data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exam and as the burial-trag certificate be execu Due to (or as a consequence of): Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ۾ 3 Probably 4 ☐ Unknown 1 🗌 Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an certificate has autopsy performe The 1 □Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ၀ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No completely filled in by the 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check o and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signat 100 rson who completed cause of death (Item 33a) (Type, 30. NameAand address of 60 run de 31. Date filed (Month) Year) 32. Registrar's Signature State 15

Registrar

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be execu	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-tran	
3	4				

	1 - For State Registrar	Olate of	iviai yiaite		tificate of De			eg. No.2 0	9 24491
	1. Decedent's Name (First, Middle, La	ist)					2. Date of Deat		3. Time of Death
ian cal	Saundra L. Lang						JUN 34	2007	0242 M
ner	4a. Facility Name (If not institution, gir	ve street and num	ber)		4b. City, Town, or Lo	cation of Death		4c. County of	of Death
	Seasons Hospice a	t Northw	est Hos	pital		lstown		Balt	imore
		Sex 7 1 □ M 2 🖾 F	. Age (In yrs. la 43			Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 4/6/196	Year)	Birthplace (State or Foreign Country) ND
	Usual Residence of Decedent						4/0/170	0	ND
	10a. State 10b. County		10c. City,	Town or Loc	cation				10d. Inside City Limits
ţ	MD Anne Ar	undel	S	evern	a Park				1 □Yes XX No
irec	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	hat Country?
<u>=</u>	371N Drive				211	46		1	USA
by Funeral Director	11. Marital Status	12. Was Deced		. 13. V	Vas Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Sp	ecify Yes or No-		- American Indian,
F	1 ☐ Never Married 2 ☐ Married	Armed Ford 1 Tyes 2 If Yes, Give	2 x 3 % 0			Specify:	riioari, etc.)		k, White, etc. White
l by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	tes:		200	spoony.		Specify:	
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I du	Elementary/Secondary (0-12)	College (1-	4or 5+)		sabled			N	/A
ပိ	17. Father's Name (First, Middle, Las	<i>t</i>)		DI		Mother's Name	e (First, Middle, M		
Be	Eugene Bolyard	.,			"		n Willar		-/
٩	19a. Informant's Name/Relationship	(Type Print)		19h Mailin	q Address (Street and	d Number or Rus	al Route Number	City or Town.	State, Zin Code)
	Joshua Lang	Son			Sommit DR.		olis, MD		,
	20a. Method of Disposition	DOII	20b. Pla		sition (Name of natory or other place)				City or Town, State
	1 ☐ Burial 2XCXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		tate		Crematory	7/11/	/2009	Clan Ru	rnie, MD
	21. Signature of Funeral Service Lice		1161		. Name and Address				
	13: 2. Com	_			Ridgely A		napolis,		•
	23a. Part 1. Enter the disease, or con	nplications that ca	used the death.	. Do not ent	er the mode of dying,				Approximate Interval Between
	shock, or heart failure. List only Immediate Cause (Final			Ma	2000,001	1 (11)	of 1 10	40	Onset and Death
	disease or condition resulting in death)		or as a conseque		noconcu	LUPPICE	4 60	4	
		,							
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (c	or as a conseque	ence of):					
ami	Cause (Disease or injury that initiated events	c							
Completed by Physician/Medical Examiner	resulting in death) Last	Due to (c	or as a conseque	ence of):					
dica	•	d							
ĕ.	IF FEMALE:	00- 16							
lan	23b. Was decedent pregnant in the past 12 months?		irth 2 🗍 Fetal	death 3	Ectopic pregnancy			23d. Date Mor	e of delivery nth Day Year
ysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9 ☐ Unkno	ant at time of de wn	eatn 5L	Other (specify)				
P.	Part II. Other significant conditions	contributing to dea	ath but not resul	Iting in the ur	nderlying cause given	in Part I.	23e. Did tol	pacco use contr	ibute to the cause of death?
d b							1 □ Ye	s 2 No	3 ☐ Probably 4 ☐ Unknown
ete							24a. Was a	n 24h. V	Vere autopsy findings available
l m							autops perform	ned? d	Vere autopsy findings available prior to completion of cause of leath?
	25. Was case referred to medical					6 Place of Deat	1 ☐ Yes h (Check only on	1	☐Yes 2 ANo
o Be	examiner? 1 ☐ Yes 2 📉 No	Hospital:	patient 2 🗆 E	ER/Outpatier	nt 3 DOA Other:		ome 5 Reside	5	A SONS ITOSPICE
n.	27. Manner of Death			28b. Time of			28d. Describe ho		
li i	1 Natural 5 Pending 2 Accident investigation		n, Day, Year)	Injury		s 2 No			
ifica	3 Suicide 6 Could not 4 Homicide determined	be 28e. Place of	of Injury - At hor	me, farm, str	eet, factory, office		28f. Location (Si City or Town	reet and Number	er or Rural Route Number,
Cert	Tiomicide	Dallalli	g, etc. (Opcon)	/			Oily of Tom	, olarcy	
Medical Certification: To					h occurred at the time vestigation, in my opir				anner as stated. and due to the cause(s)
ledi	one)	and mann							
	29b. Signature and title of certifier	, R.	1		29c. License r	721		1 1	(Month, Day, Year)
	- Mundelli	e jour	w		1110	1		JULY	8 th 2009
	30. Name and address of person who	16 BW	ton	23a) (Type, 283	5 Smith	Avanc	16 Bal	tmore	MD 21209
ate rar	31. Date filed (Month, Day, Year) JUL 15	2009 32.	egistrar's Signat	b. So	ake				MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#20b, perFH, 7/16/09, DPS, McCo

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ". 20 AM cecqueline leana 2009 13 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Rehab Montgomery **Burtonsville** Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🕱 F Yrs. Wisconsin April 30, 1934 Director 387-30-3667 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Director Takoma Park Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20912 ILS.A. 317 Lincoln Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Work 5+ Psychiatric Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beverly Peterson 2 James Stephens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2629 West Lake Isle Drive, Mequon, Wisconsin Vincent A. Megna - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 7/17/09 4 □ Donation 5 □ Other (Specify) 07/07/2009 Brentwood, Maryland Fort Lincoln Crematory 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center 21. Signature of Funeral Service Licens e Edmonston Crossing Shopping Center, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ND Stage **Physician** /Medical Due to (or as a cons quence of): Examiner irrhosis Sequentially list conditions, Due to (or as a consequence of) Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physician the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No Day Year fo 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö 9 Unknown σ, signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2**X** No 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has ; autopsy performed' certificate 2 No After this certification Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 2 ER/Outpatient 3 DOA 9 1 ☐ Yes 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours at er death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Š 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check o within 24 one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature

State Registrar 30. Name and address of perso who complete

Year)

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2009

31. Date filed (Month)

se of death (Item 23a) (Type, Print)

25 mark

32. Registrar's Signature

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Sure 200 Reesterstown, Md 21136

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	Physici		1. Decedent's Name (First, Middle, Last) Bernw D	4. Myles				2. Date of De. Month	ath Day J A	<i>0</i> 09	3. Time of Death 3145 M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number Rchal	b	4b. City, Town, o	Cocation of Death	1	4c, County AA	of Death	
	Funeral Director		5/9.17.300	M 2 □ F 87	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 8/2/19	th y, Year) 921	9. Birthplac Country Mary1	
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	with With		2837 White House H	?d		2114	10		USA		•
36	rs after death I', or Items 2:	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1942-4		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 No	fispanic Origin? (S an, Mexican, Puerl	pecify Yes or No o Rican, etc.)	- 14. Rac	e - American ck, White, etc	
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Mar	12 shou and M is mar reumati		19a. Informant's Name/Relationship (Type			ng Address (Street				State, Zip C	ode)
Baltimore, 1	ges 1 and 2 should t of Health and Mer If Item 27 is marke or other treumatic		Gregory S. Myles/ 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	20b. Pia	ice of Dispo	Spa Drive esition (Name of matory or other place		Date	20c. Location -	City or Town	n, State
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ds, P	uires that signed b	by	Part II. Other significant conditions con	tributing to death but not resul	ting in the u	inderlying cause gr	ven in Part I.	1	obacco use cont Yes 2□No		cause of death?
Il Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed						24a. Was auto perfo 1 Yes	psy ormed	prior to comp death?	y findings available oletion of cause of
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Division	tend teath tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, st]Yes 2□No	28f. Location (City or To	Street and Numb wn, State)	ber or Rural I	Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical C		sician: To the best of my knowner: On the basis of examination and manner stated.							
•	To the Ho within 24 I To the Fu completel	Me	298- Signature and title of certifier	iddle - Fre	y CK	NP R13	se number 5104		29d. Date signe	od (Month, Da	ay, Year)
19	1484		30. Name and address of person the co	mpleted cause of senth (Item	23a) (Type	53 Med	ical A	Kmy, y	Annap	. My	21461
	Sta Regist		31. Date filed (Month, Day, Year) JUL 15 20	32. Registrar's Signat	d. A	back		1			

DHMH 17 Rev 1/2001

		1- State of Maryland / Department of Health and Certificate of Death		ene 0 0 9 2449
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Suzanne Miller	2. Date of Death	3. Time of De 3. 45 A
Examin Funeral		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat 4c. City, Town, or Lo	8. Date of Birth	4c. County of Death Anne Arunol Cl (ear) 9. Birthplace (State or F Country) OH
Director		365-34-7945 1□ M 2MF 76 Yrs. World's Days Hours Wall. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	4/24/19	10d. Inside City
r 28a-f sh	rector	MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code	10g	1 ☐ Yes 🛂
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hin 72 hours a b. an "natural", c	Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) If Yes, Give Year or Dates: 1 ☐ Yes 2 ► No Specify:	rking 16	Specify: WITEC
2 should be filed withing and Mental Hygiene. Is marked other then eumatic event, Ire Mental Hygiene.	To Be Com	17. Father's Name (First, Middle, Last) 4 Homemaker 18. Mother's Name	me (First, Middle, Ma	Own Home
and 2 shoul saith and Me n 27 is mark	Ĕ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ri	ural Route Number, (polis, MD	City or Town, State, Zip Code)
Pa ne ne ne ne ne ne ne ne ne ne ne ne ne			1/2009 G	len Burnie, MD
permit. Pag Department importent: I any injury o			Hardesty I nnapolis,	Funeral Home, P.A. MD 21401
Physician Medical Examiner and Inspired Physician and Inspired Physi	cai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of the such as cardia shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list runditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Congestive Heav + fair Due to (or as a consequence of): d. Atrial Fibrillation	2	t, Approximate Interval Betwee Onset and De
ath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Ye
quires that the de in signed by the a uld be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of dea
ate h page	Completed		24a. Was an autopsy performe	24b. Were autopsy findings av prior to completion of cau death? 5 No 1 \(\text{Yes} \) Yes 2 \(\text{No} \) No
Physicien; The this certificate ral director, pag	Be	examiner? Hospital: Other	ath (Check only one)	C = 0 = (C(1)
ding h. After fune	Certification: To	27. Manner of Death 1	28d. Describe how	ce 6 □Other (Specify) r injury occurred met and Number or Rural Route Number
E Pire		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place	City or Town,	State)
To the Hospitel within 24 hours and the Funerel completely filled	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and the procedure of certifier 29c. License number	urred at the time, date	e and place, and due to the cause(s) d. Date signed (Month, Day, Year)
<u> </u>		Leventh Ut at. D. Dooloz		7/10/2009
+6		30. Na dress of person who completed cause of death (Item 23a) (Type, Print) STEVEN HAMLETTE, M.D., 2001 Medical Par 31. Date filed (Month, Day, Year) 32. Registrar's Signature	rkway Ann	napolis, MD 21401

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Weikert Anna Newcomer July 15, 2009 6:28 /Medical P. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Senior Living Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 3, 9. Birthplace (State or Foreign Country)
Pennsylvania 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1923 1 M 2 X F 86 Yrs. Director 190-12-3722 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show show 14 Yes 2 □ No Director Md. Montgomery Brinklow the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it. Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 and 10 injury or other traumatic event, the Muchael Eventual. 19801 New Hampshire Ave. 20862 U.S.A by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 □Yes 2 □ No Specify. Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Bank 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Weikert Maude G. Spangler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19805 New Hampshire Ave. Brinklow, Md. 20862 Linda Newcomer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ringgold Cemetery 20a. Method of Disposition $Julu^{Date}$ 21, 20c. Location - City or Town, State **X** Burial 2 ☐ Cremation 3 ☐ Removal from State Ringgold, Md. 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21782 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alzheimers Disease 4 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsease on Injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and burjai-trar Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician I be detached for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 icate has been sign, page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown *Depression* Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗹 No Division of Vital 1 ☐Yes 2 ☐No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Checker (Specify) Assisted 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Living the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the I within 2. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

THE

DHMH 17 Rev 1/2001

Registrar

410 Car 20

D56531

8600 Snowden River Parkway #301 Columbia, Md. 21045

July 20, 2009

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Harry Li M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 0425 **Physician** SWERR MAGNER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 3/10/1924 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10M 20 F Months Washington, DC 85 Yrs. 192-14-6786 Director Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State If item 27 is marked other then "neturel", or items 23a or 28a-f show or other treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 805 Bridgeport Way death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes. 2 □ No If Yes, Give Year or Dates: 1943–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Itemens in jury or other treuments. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ years Educational Administrator 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be John Thomas Powers Leversia Long ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 805 Bridgeport Way, Annapolis, MD 21401 Eleanor R. Powers/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/14/09 Kalas Crematory Edgewater, Maryland ¹ 4 □Donation 5 □ Other (Specify) 21. Signatur Serve Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DISFARE Immediate Cause (Final THENOSCIENTIL C.U-سعق با PATENSIVE Physician disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death use 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year ō in the past 12 months? signed by the at d be detached fo 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA hours after death.

uneral Director: After this y filled in by the funeral di 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

To the Hospitel or Attending Physician: 24 hours a

29c. License number

29b. Signature and title of

721438

29d. Date signed (Month, Day, Year)

Harway ANNAPOLE MOLINGE

ion no completed cause of death (Item, 23a) (Type, Print) DEFENSE M 4TH EID MICHAN

32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

within 2 To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day **Physician Potts** Arthur Craig /Medical 09 2215 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Cumberland
If Under 1 Year | If Under 24 Hrs. WMHS Braddock Campus <u>Allegany</u> 9. Birthplace (State or Foreign Country)
D.C. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year)
Jul 27, 1948 8. **Funeral** Months Days Hours Min 1 □ M 2 □ F 215-54-7691 Director 60 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Mudical Evaminer must be notified at MD Allegany Lonaconing Director 1 □Xes 2 □ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6918 Avilton Lonaconing Road 21539 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes Yes No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ Specify. 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer Dept. Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack C. Potts Ruby Lee Bryant Potts ပ 19a. Informant's Name/Relationship (Type. Print)
Richard Potts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau brother 6918 Avilton Lonaconing Lonaconing MD 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Hemoval from State Scarpelli Funeral Home, P.A. 7/24/2009 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician Cho las /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed burial-transi Exami Due to (or as a consequence of): physician a Box 68760, Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Yea 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 2 No death? 1 ☐ Yes 2 ☐ No certificate 1 □ Yes Physician: director, 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2.E(No 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation Hospital or Attending 1 → Matural 2 → Accident death. n 24 hours after death.

e Funeral Director; A

letely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUNIL GUDTA

625

32. Registra/'s Signature

DHMH 17 Rev 1/2001

DIL

ORIGINAL

29c. License number

00033280

AVENUE Comberland, ND 21502

29d. Date signed (Month, Day, Year)

¥	4		- State of Maryland / Dep - State Amend Items 23aPtI,25,27,28a-f Registrar	artment of Health ar per me, 893,077 prtificate of Death	od Mental Hygio	ene g. No. 2009 24498		
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year		
ing.	/Medic		Pauline Peterson Reynol	June	2 2009 1420 P ^M			
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of [Death	4c. County of Death		
1			SunBridge Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Elkton If Under 1 Year If Under 24	Hrs. 8, Date of Birth	9. Birthplace (State or Foreign		
	Funeral Director		216-28-9280 1□ M 2♥F 75 Yrs.		Min. (Month, Day, April 30,	Year) Country)		
	D		Usual Residence of Decedent		11,01111 301			
	show	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits					
	8a-f	ecto	Maryland Cecil Elkton		140	1 X Yes 2 □ No		
	a or 2	Ē	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?		
	eath v	eral	150 East Main Street, Apartment 201 11. Marital Status 12. Was Decedent Ever in U.S. 13	21921 Was Decedent of Hispanic Origin	n? (Specify Yes or No-	United States 14. Race - American Indian,		
(0	fter d r iten	by Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	If Yes, specify Cuban, Mexican, F	uerto Rican, etc.)	Black, White, etc.		
036	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show he Medical Evan ing the notified at	by	3 🕅 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 📉 No Specify:		Specify: White		
2-0	72 ho	To Be Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	f working 16	6b. Kind of Business/Industry		
121	ithin ne.		Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		T II O II		
5	iled w Hygie ther t nt, th		10 Ho	omemaker	Name (First, Middle, Ma	In Her Own Home		
Maryland 21215-0036	d be feat all sed of ceve		Reuben Peterson		Renfrow	accon cameno,		
Σ	shoul nd Me mark imati			ing Address (Street and Number		City or Town, State, Zip Code)		
Š	of Health a litem 27 is		Debbie Hunter/Daughter 104	Mallard Court,	Elkton. MD	21921		
J.e.	of He item		20a Method of Disposition 20h Place of Disp	osition (Name of		Oc. Location - City or Town, State		
<u><u><u></u></u></u>	Page ment ant: It ury o		4 Donation 5 Other (Specify) Memorial	Park 20	009	Elkton, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanciant or just be notified at once.		21. Sign ture of Funeral Service Licensee	2. Name and Address of Facility	unerals. P.	Α.		
_	ਰਹ = 400	1	Jones S. Acces 1	03 W. Stockton	Street, Elk	ton, MD 21921		
		`	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.			Interval Between		
The state of the s	Physician /Medical		disease or condition disease or condition as S/F Multiple is death) as S/F Multiple is death)					
r	Examiner	er	Due to wras a consequence of: Complications					
			Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of F	e // //	11			
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	al portsy	- EVAMINER			
ó,	ian al	Ë	Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Spastic Facial Parcy CERTIFICATION Due to (or as a consequence of): Spastic Facial Parcy CERTIFICATION DUE TO STANDING DUE T					
8760,	ficate be executed physician and s the burial-transit	dical	d	aERT.	FICATION APPROV			
9	ding page as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	CEN		1		
Вох	death certific e attending p d for use as	sian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year		
Ö	0 0 0	Physician/Me	1 ☐ Yes 2 📆 No 9 ☐ Unknown 9 ☐ Unknown	□ Other (apecity)				
т. О.	The law requires that the ate has been signed by the page 2 should be detache	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death?		
rds	w requires t s been signe should be		<u>HTN</u>		1 □ Yes	2 □ No 3 □ Probably 4 ∰Unknown		
900	e law re has bed je 2 sho				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
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/ita	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?		Death (Check only one))		
of/	Physical this of all dire	Certification: To	1 X Yes 2 Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify)					
uc	ding F		27. Manner of Death → Natural 5 □ Pending (Month, Day, Year) Investigation investigation	Wn Work?	Needle s	truck nerve during		
Division of Vital Records,	Attending ir death. ector: Afte by the fune	fica	Unknown Unkn	OWIL	denear p	rocedure;Subject fell. eet and Number or Rural Boute Number.		
Ö.	al or / s after I Dire	Medical Certi	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Unknown; Dental Office 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Unknown; Unknown Unknown					
	To the Hospital or Attending Physician: The within 24 hours atter death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)					
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in b		one) and manner stated.	29c. License number				
	5 × 6 §	-	29b. Signature and title of certifier	D0062		d. Date signed (Month, Day, Year)		
			. 0//			6/2/2009		
	5		SHAHNAWAZ A. KHAN III		SUITE#10	5, EUKTON, MD 21921		
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 9 2009 32. Registrar's Signature	lad				

DHMH 17 Rev 1/2001

			For State Registrar		Certificate of	Death	R	eg. No. 200	3 24499
	Physici /Medic		1. Decedent's Name (First, Middle, Last) William A. Ross				2. Date of Deat July 1	L3 ^{Day} 200 ⁹ ar	3. Time of Death 9:45A. M
-	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rockville 4c. County of Death Montgomery						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show be used in injury or other traumatic event, it when the informatic be ruffilled at any injury or other traumatic event, it when the informatic be ruffilled at the informatic event.	tor			hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Aug • 30	9. Bio 1922 Wes	rthplace (State or Foreign owntry) St Virginia
			Usual Residence of Decedent 10a. State Maryland Montgomer	y Silver	or Location Spring				10d. Inside City Limits 1 □ Yes 2 → No
		Funeral Director	10e. Street and Number 3122 Gracefield Ro	ad, CT#613	10f. Zip Code 20904		1	og. Citizen of What C United Sta	•
980		To Be Completed by Funer	11. Marital Status 1 Never Married 2 Married 3 MWidowed 4 Divorced	2. Was Decedent Ever in U.S. Amed Forces? 1 XiYes 2 No IYes, Give Year or Dates: 1940-1961	13. Was Decedent of If Yes, specify Cut 1 □ Yes 2 ☒ No		pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
21215-0036			15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	completed) College (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation e during most of work ed)	ing	16b. Kind of Business Eye Care	:/Industry
land 2			17. Father's Name (First, Middle, Last) Charles J. Ross			18. Mother's Nam Martha E		Maiden Surname)	
, Mary			19a. Informant's Name/Relationship (<i>Typ</i> Sandra Ross Aquino	e. Print) 19bdaughter 31	Mailing Address (Stree 40 San Mich	t and Number or Ru nele Driv	rai Route Number re Pa l m F	r, City or Town, State, Beach Garde	zip Code) ens, FL33418
Baltimore, Maryland		/	20a. Method of Disposition 1	emoval from State 20b. Place of cemeter. Gate of	Disposition (Name of y, crematory or other pla f Heaven Ce	emetery 7/	^{15/2009}	20c. Location - City of Silver Sp.	rTown, State ring, Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	ngwalt	Donald V 4400 Powde	ess of Facility Borgward er Mill Ro	lt Funera ad Belts	al Home, Pa sville, Man	A ryland20705
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Hepatocellular Carcinoma Due to (or as a consequence of):						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):				
68760,		d by Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
O. Box 687			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy		23d. Date of do	elivery Day Year
ds, P.			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastrointestinal Bleed; COPD					e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	
of Vital Records,		Completed by					24a. Was a autops perform	sy prior to	autopsy findings available completion of cause of
Vita		Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Ou			th (Check only on		
o		7: To	27. Manner of Death	4 ☐ Nursing Hury at ork?		ence 6 ZOther (Sp	espins nome		
Division		Certification:	1 Natural 5 ☐ Pending investigation 3 ☐ Suicide 6 ☐ Could not be determined	(Month, Day, Year) Ir 28e. Place of Injury - At home, far building, etc. (Specify)	M 1]Yes 2□No	28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
		Medical Ce	29a. Certifier (Check only one) (Check only on						
		Med	29b. Signature and title of certifier	and manner stated.		nse number -010105811		July 14,	
•	12		30. Name and address of person who co Sam Wanko, M.D. Na	visconsin Av	enue Bethe	esda, Marylan	nd 20889		
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature Aparks Aparks									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009^{Year} Day Month **Physician** Alberta Rosetta Riley July 2:40A. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3385 Yellow Springs South Anne Arundel Laurel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 75 Yrs. 8. Date of Birth Feb. 15, 1934 **Funeral** Days Delaware 1 ☐ M 2 💢 F 214-30-8810 Director Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Eventires must be notified at once. Maryland 1 □ Yes 2 No Anne Arundel Laurel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 3385 Yellow Springs South 20724 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Store Clerk private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Trusyant Norman Johnson Elizabeth Blake ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gwendolyn Girlie -Daughter 3385 Yellow Springs South Laurel, Maryland 20724 altimore, 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Md. Veterans Cemetery 7/15/2009 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bonaldo WiresBorgwardt Funeral Home, PA 21. Signature of Funeral Service Licenses 4400 Powder Mill Road Beltsville, Maryland20705 U 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ovarian Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Intestinal Obstruction Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examil burial-transi and Due to (or as a consequence of) attending physician for use as the burial Box 68760. pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy performed? Yes 2 2 No 1 Yes 2 No 1 🗆 Yes Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No e Hospital or Attendi ≥ 4 hours after death. e Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

To the within 2.

Registrar

completely

(Check only

29b. Signature and title of certifier

Vincent Edward Sutliff, III 8329 Cherry Lane Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 16

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

parked

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D50070

29d. Date signed (Month, Day, Year)

July 14, 2009